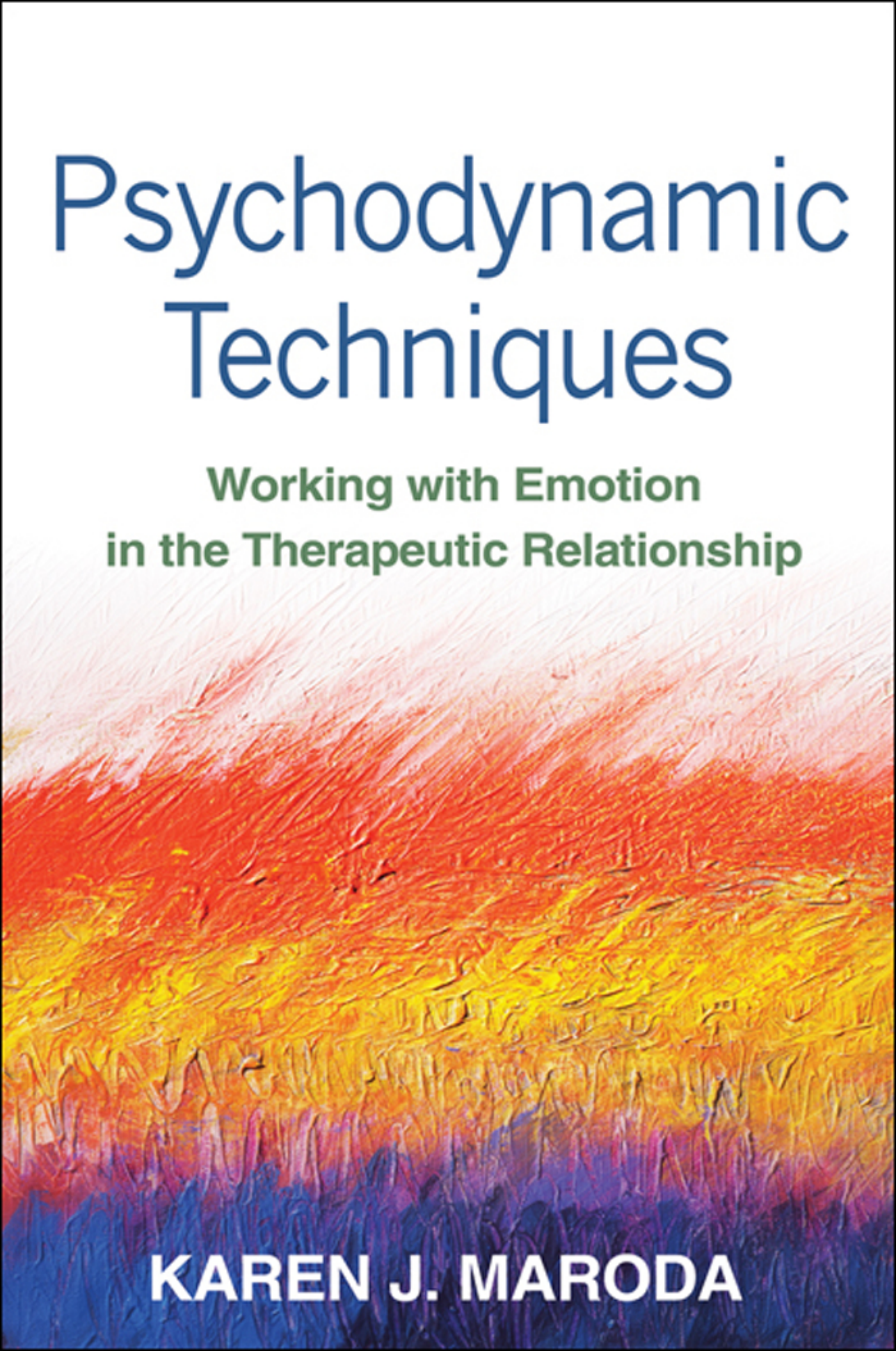
Psychodynamic Techniques

Working with Emotion in the Therapeutic Relationship



KAREN J. MARODA

SHOUT
SHARE
IT

PSYCHODYNAMIC TECHNIQUES

PSYCHODYNAMIC TECHNIQUES

Working with Emotion in the Therapeutic Relationship

KAREN J. MARODA

THE GUILFORD PRESS
New York London

© 2010 The Guilford Press
A Division of Guilford Publications, Inc.
72 Spring Street, New York, NY 10012
www.guilford.com

All rights reserved

No part of this book may be reproduced, translated, stored in
a retrieval system, or transmitted, in any form or by any means,
electronic, mechanical, photocopying, microfilming, recording,
or otherwise, without written permission from the Publisher.

Printed in the United States of America

This book is printed on acid-free paper.

Last digit is print number: 9 8 7 6 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Maroda, Karen J.
Psychodynamic techniques : working with emotion in the therapeutic relationship / Karen J. Maroda.
p. cm.
Includes bibliographical references and index.
ISBN 978-1-60623-492-1 (hbk. : alk. paper)
1. Psychodynamic psychotherapy. 2. Psychotherapist and patient. 3. Emotions. I. Title.
RC489.P72M336 2010
616.89'14—dc22

2009036422

Chapter 9, "Erotic Feelings: How They Help or Hinder the Therapeutic Process," is adapted from a paper entitled "Desire, Love and Power in the Therapeutic Relationship," published in the *British Journal of Psychotherapy Integration,* Volume 3, Issue 2, pages 6–12, November 2006. Copyright by the United Kingdom Association for Psychotherapy Integration. Adapted by permission.

About the Author

Karen J. Maroda, PhD, ABPP, is Assistant Clinical Professor of Psychiatry at the Medical College of Wisconsin and in private practice in Milwaukee, Wisconsin. She is the past ethics chair and board member of Division 39 (Psychoanalysis) of the American Psychological Association and past president of Division 39's Section III, Women, Gender, and Psychoanalysis. The author of two previous books, *The Power of Countertransference* and *Seduction, Surrender, and Transformation,* Dr. Maroda has also published numerous journal articles, book chapters, and book reviews. She lectures nationally and internationally on a variety of aspects of the therapeutic process, including the place of affect, self-disclosure, countertransference, legitimate authority, and the need for clinical guidelines. Dr. Maroda is on the editorial board of two major journals, *Psychoanalytic Psychology* and *The Journal of Gay & Lesbian Psychotherapy* and is corresponding editor of *Contemporary Psychoanalysis*; she actively encourages her colleagues to write and talk about what they actually do as therapists.

Acknowledgments

Writing a book on technique proved to be the most challenging project I have undertaken. The difficulty in writing such a book centers on the dilemma of needing to be experienced to give guidance, yet needing to write with a keen understanding of what new therapists are experiencing. As I discussed this quandary with my friend and colleague Michelle Waide, she offered to create a study group of experienced and inexperienced therapists who would read each chapter and give me feedback. This group comprised senior therapists Mary Griffiths, Gwen Werner, and Michelle, and newer therapists Brian Smothers, Heather Kennedy, and Katie Hornada. We arranged to meet at my house to discuss each chapter. As each person entered, the smell of fresh coffee brewing, he or she brushed the Wisconsin snow and cold away, settling in to talk and nibble at muffins and fresh fruit. Our meetings were relaxed and informal. Soon our conversations became as much about our lives and our trust in each other as they were about the book. We revealed our own experiences as therapists, and the group gave me valuable feedback and support on everything from clinical insights to word choice. I am appreciative of the many hours they spent reading and critiquing the manuscript, and for their willingness to be candid about what worked and what didn't. We are talking about a follow-up project devoted to case examples, if for no other reason than to reunite the group for our Friday morning meetings.

As always, I am grateful to my clients, especially "Nancy" and "Rebecca," who gave me permission to write about them extensively. I continue to be awed by the therapeutic process and the capacity for transformation. I also want to thank my family and friends, who pro-

vided continued moral support, especially when I felt overwhelmed by the size of the task I had undertaken.

Thanks to Jim Nageotte, Senior Editor at The Guilford Press, who provided my first experience of a complete professional manuscript edit. Never having experienced one before, I was initially nonplussed by the sight of chapters e-mailed back awash in "red ink." But I came to appreciate the value of examining every word, eliminating even small digressions, and replacing ambiguous statements with clear ones.

Finally, I want to thank the many young therapists who convinced me that they would love to utilize psychodynamic theory more in their work, but had no idea how to do so. They urged me to write a text that would provide some guidance. My meetings with groups across the country helped keep me motivated. As I was approaching the last third of the writing, I spoke in Seattle at the Mars Hill Graduate School at the invitation of Roy Barseness, a faculty member who had read and taught my previous work with insight and enthusiasm. The tremendous response I received over the weekend there, working with over 100 bright and curious graduate students and new therapists, reenergized me and helped me to see how great the need was for clinical guidelines. It is the students whom I teach, who write to me, and who approach me after lectures that inspired me to write this book, and I dedicate it proudly to them.

Contents

	Introduction	1
1	Emotional Engagement and Mutual Influence: Basic Issues as Therapy Begins	5
2	Mutuality and Collaboration: Influencing Each Other	30
3	Redefining Regression: Facilitating Therapeutic Vulnerability	56
4	Evaluating Interventions: Tracking the Client's Response	82
5	Self-Disclosure and Advice: Understanding How and When the Therapist's Disclosures Are Therapeutic	107
6	Managing Emotion: Affective Communication and the Role of Interaction	136
7	The Special Problem of Affect Management in Treating Borderline Personality Disorders	153
8	Confrontation and Countertransference Anger: Overcoming the Therapist's Aversion to Conflict	179

9	Erotic Feelings: How They Help or Hinder the Therapeutic Process	204
10	Empowering the Client: The Road to Independence	225
	Conclusion	243
	Glossary	245
	Annotated Bibliography	251
	References	257
	Author Index	267
	Subject Index	271

PSYCHODYNAMIC TECHNIQUES

Introduction

As new therapists begin their work with real clients in the real world, they often discover that no matter how well they have been trained, at some level they are singularly unprepared for the reality of responding to another person's pain. Confidence comes with knowledge and experience, of course. But the central idea presented here is that therapists can benefit from a closer examination of the therapeutic process, especially by keeping in mind that therapy is a relationship involving ongoing conscious and unconscious communication. The essential aspect of that communication centers on affect and attachment. I firmly believe that techniques for facilitating affective communication can be taught.

This book is written primarily for new therapists, but I believe it has a great deal to offer experienced therapists as well. My goal in writing this book is to aid therapists in their struggle to meet the needs of the troubled clients who come to them with the expectation that they will be knowledgeable and helpful. I also want to illustrate that psychodynamic therapy remains a vital and viable form of treatment, one that requires skills that can be taught. A new therapist will often rely on behavioral approaches simply because these approaches have established techniques. Yet I invite you to step beyond practice manuals, to explore and consider the depth and complexity of human nature that is uniquely addressed in psychodynamic theory and practice.

The perspective offered in this volume is that the therapist and the client achieve the best results when they establish a collaborative working relationship. When I read the literature, I find the focus is mostly on

how the therapist thinks about the *client* rather than how the therapist thinks about the *relationship*. Therapists tend to ask themselves "What should *I* do?" rather than "What needs to happen in this relationship right now, and what is the best way I can facilitate that?" This book is written from the perspective of therapy as a relationship, albeit an asymmetrical one, that exists within professional boundaries. It examines the ways both therapist and client think and feel within the relationship. More importantly, it outlines specific ways of responding to clients based on understanding the role of emotion in the therapeutic process.

The research on affect and attachment has revealed that we are all emoting constantly, even though sometimes outside of our conscious awareness. Managing this emotional flow within the therapy relationship is challenging for the therapist, who requires both knowledge and skill. When I began working with clients I did not possess that knowledge and skill. The most compelling truth I faced as a new therapist was how vulnerable I was. Optimistic, but unprepared, I remember sitting with a client who was very likable, yet overstimulating, thinking, "I have no idea what I am doing." Nothing I learned in training prepared me for the emotional roller coaster I was on.

What I had been taught got me off to a good start. I was empathic, a good listener, genuinely concerned, attentive, and professional. My clients responded by going deeper and deeper into their own experience. This inevitably led me to go deeper and deeper into my own feelings. But I had no working knowledge of affect management. I wondered how I should be responding, internally and externally, to all the emotion in the room.

Beginning my personal analysis soon after I started practicing helped me to see what my own clients were looking for. My analyst kept too much of a distance and refused any real conversation with me. Soon I understood my clients' frustration at firsthand. But I still didn't know what I should be doing, or even what my analyst should be doing. I knew that everything I wished for from my analyst wasn't possible, or therapeutic. So what was it that I needed from her that would be genuinely helpful? And what should I be providing for my own clients? I didn't know, but I wanted to find out, and began experimenting.

I described these early experiments in my first book, *The Power of Countertransference* (1991), which addressed the moments when my clients pressed me to reveal what I was feeling toward them. I carried out my experiments with sweaty palms and a queasy stomach, but found

they paid off when therapeutic impasses were broken. Should every new therapist endure this kind of trial by fire, or could some shared clinical wisdom and experience provide a smoother path?

Many of my colleagues have expressed concern that providing clinical examples and advice will inevitably be misapplied and taken as hard-and-fast rules. Although I admittedly cannot prevent that from occurring, it is definitely not the spirit in which I provide guidance in this volume. Certainly, our interactions with our clients are unique and organic. There is no one-size-fits-all prescription for how to treat clients effectively, even when they have very similar problems or histories. So I agree that the notion of a step-by-step manual for doing psychotherapy is unrealistic, but so is failing to provide new practitioners with any practical advice or guidance.

Therapists need to have some idea of how to accompany their clients on their journey toward transformation. What is supposed to happen once we have gone through the initial sessions? What happens once clients trust that we understand them and that they are safe with us? Yes, some clients just need to talk, and be listened to, for a very long time. But others ask for feedback and stimulate feeling in the therapist early on. Eventually, every client needs some type of response from the therapist that goes beyond empathy and beyond a behavioral suggestion. They need a response that arises genuinely from the *emotional* connection they share with the therapist.

Younger clients, in particular, often ask for advice and want to know how the therapist sees them. Traditionally, the response was supposed to be, "How do you imagine that I see you?" Clients who need a concrete response will predictably respond to repeated evasions with frustration, anger, or withdrawal. In this text I provide numerous clinical examples showing how I have responded to my own clients during various emotional encounters. I have included comprehensive descriptions of my internal process leading up to a specific intervention, along with what my clients had to say at the time. I realize that providing this much information leaves me open to criticism and hindsight-based conjecture, but it also provides the reader with an essential keyhole look into the therapeutic process.

While the book offers specific clinical techniques, I leave plenty of room for therapists to express themselves as individuals by adapting these techniques to their own personal style. I am outgoing and gregarious, but I do not believe in a preferred personality style for therapists. All the interventions I recommend in this book can be executed equally well by both introverted and extroverted therapists. The overriding

principle that guides my choice of interventions is emotional honesty. I never recommend that therapists express themselves in any manner that they are not comfortable with, for the simple reason that it will not be therapeutic.

This volume begins with a basic review of the shared anxieties, hopes, and expectations of therapist and client. The chapters that follow are devoted to discussing the greater emotional complexities that arise as the process evolves—especially in a longer treatment. Included is an exploration of less frequently discussed topics, such as how basic empathy becomes deeper and more complex over time; how to identify and manage regression; how to establish a collaborative therapeutic relationship, noting the contributions of both therapist and client; how best to implement self-disclosure and advice; how to manage affect, including bringing emotion into the session when it is lacking; how to recognize when sexual and loving expressions are therapeutic and when they are not; how to use confrontation productively; and how to evaluate interventions.

I hope readers will immerse themselves in this material and come away with both greater insights into the therapeutic process and with practical tools for therapeutic success. Perhaps, with a little guidance, more therapists will feel confident enough to plumb the depths of emotion within the therapeutic relationship—and in so doing will assist their clients in their search for health, personal freedom, and fulfilling relationships with others.

1

Emotional Engagement and Mutual Influence

Basic Issues as Therapy Begins

> The most important source of resistance in the treatment process is the therapist's resistance to what the patient feels.
>
> — Paul Russell (1998, p. 19)

As much as we want to be present and to feel our clients' pain, we also naturally fear that same experience. Part of our resistance to receiving our clients' disturbing feelings is that psychotherapy training has not traditionally included a discussion of the therapist's feelings and how to use them constructively in the therapeutic interaction. In the last two decades, much emphasis has been placed on therapy as a relationship. A successful treatment arguably has more to do with the therapist–client relationship than with anything else. Navigating *any* relationship that entails the expression of deep emotion is naturally challenging. The premise of this book is that therapists need more insight and more effective strategies for actively responding to their clients. They need to better understand how and why clients express strong emotions as the therapy unfolds, and how and why their own feelings emerge in tandem. They also need teachable *interactive* skills they can implement on a daily basis.

The literature on affect confirms that, in a relationship, the more intensely one person expresses emotion, the more likely the other person is to share that experience, both consciously and unconsciously (Sullins, 1991). Also, the more we like and identify with the person we

are treating, the more intensely empathic we will be (Hess & Kirouac, 2000). Nothing quite prepares any therapist for the reality of sitting quietly in a room with another human being who is in intense emotional pain. The therapist's emotional and visceral reactions to his client's feelings can be moving, but also disturbing. The client's emotional impact on the therapist is arguably the most neglected area in therapist training.

Trauma counselors were perhaps the first group of therapists to openly discuss the "emotional contagion factor" for therapists. While treating clients who had suffered severe abuse, these therapists soon found themselves experiencing physical and emotional symptoms similar to those of their clients, and often needed to resist the client's emotions to avoid what has been labeled "vicarious traumatization" (Pearlman & Saakvitne, 1995). Although the experience of shared affect in nontraumatized clients is not so obviously difficult to manage, it nonetheless exists.

For decades most psychoanalysts viewed the client's need to influence the therapist as pathological resistance. But others, like Levenson (1972) and Searles (1979), understood that it was natural for clients to recognize that both their feelings and their intentions are received and processed by the therapist. Their intuitive understanding has only recently been confirmed by affect research, demonstrating that emotions are *meant to be received and responded to* (Kemper, 2000). One of the many functions of affects is to influence others and stimulate a response in them. This volume is devoted to understanding what the client is soliciting and needing at a given point in time.

Reconceptualizing Freud's notion of repetition compulsion, Greenberg and Mitchell (1983) and Mitchell (1988) emphasized that all people acquire certain relational patterns as they attach to their caretakers, which they subsequently repeat in all relationships, including the therapeutic one. These patterns include feelings, thoughts, and expectations learned in early childhood that are repeated unconsciously in adult relationships simply because they are familiar. Neuroscience confirms that these patterns are, indeed, laid down in the brain at an early age and do not change easily. So now we perceive our clients' need to evoke an emotional response from us as an inevitable function of their early attachments, laid down as easily triggered affect programs in the brain (Griffiths, 1997). What we do *not acknowledge* is that therapists bring the same established ways of being to every relationship. Just as our clients seek an emotional response from us, so we, as we enter into a relationship with them, seek their affective response. The patterns of

relating that are established within the therapist determine with whom she is likely to work well and in what ways she is likely to influence and be influenced.

THE IMPORTANCE OF A GOOD MATCH

Understanding that both therapist and client have relational patterns anchored in attachment makes it easier to comprehend the necessity of a good match, as well as the naturally occurring mutual desire to influence each other. If I attempt to treat someone who is too different from me, and whom I do not readily relate to, the likelihood of success diminishes. However, if I identify too much with a prospective client I can easily make the mistake of attempting to influence him based on my needs rather than his own. Ideally, a good match includes compatible styles of relating—just enough shared early emotional experience to make for a connection, but not so much as to blur the distinctions between therapist and client.

Intellectual discussions of a good match (Kantrowitz, 1995) essentially make these points, but predictably cannot offer much advice to therapists regarding whom they should treat and whom they should not treat. Matching on the basis of diagnosis has not proven to be consistently productive. Even if you have had success working with clients with bipolar disorder, for example, you cannot assume you would make a good match for most clients with bipolar disorder. Any judgments about matching patients to therapists based on diagnosis require a feel for nuances, which comes only after years of experience. But new therapists need criteria they can use when they are just starting out.

Given that new therapists struggle with anxiety, how can they make good judgments about whether to work with a particular client presenting for treatment? How does a therapist make this assessment in the first session or two in any reasonable way? And, once the relationship has been established, how do therapists avoid resisting the client's deep emotional experiences that may be uncomfortable?

From the time the client first walks in the room, I note my gut reaction to him. What do I feel when I look at him? Did he look at me when I shook his hand? What do I notice about his physicality? Do I feel attracted, neutral, removed, or put off? When he begins to speak, do I feel emotion? If so, what emotion? Do I imagine a rewarding relationship for both of us? I have discussed elsewhere (Maroda, 2005) that some degree of gratification for the therapist is necessary for the treat-

ment to be successful, especially if it is long term. Making the decision about whether to treat someone relies heavily on the therapist's access to her own emotional experience in the moment.

Does the fact that someone has presented himself for therapy mean you should treat him? I find that few therapists will admit to not wanting to take someone on. But it is not a good idea to engage in therapy, even short-term work, with someone you are either not interested in or dislike (Maroda, 1999). Given that the literature has shown that all people, places, and things evoke an immediate positive or negative response (Andersen, Reznik, & Glassman, 2005; also see Bargh, Chaiken, Govender, & Pratto, 1992; Fazio, 1986; and Russell, 2003), perhaps therapists need to be more self-aware of the potential for not working well with certain clients.

Therapists who believe they can transcend their immediate dislike of a client and provide needed empathy almost always prove themselves wrong. In order to establish a working alliance, both parties need to be sufficiently curious and interested in each other. The emotional connection that serves as a conduit for the client's experience of his own emotions will not be made if the match is a poor one.

When I presented these ideas in a workshop, one participant asked, "Who is going to treat all the unlikable people in the world if we start rejecting them?" I responded by saying that's like wondering how someone whom you are not interested in dating will ever find a partner. Just as in social relationships, if a client looks hard enough he will probably find a therapist who makes a good match. A client who is obnoxious to one therapist will be intriguing to another. Therapists who take on clients who do not elicit their curiosity and whom they do not like are doing an injustice to the clients as well as to themselves.

However, this does not mean that you should not take on a client who has negative traits or behaviors. Most of our clients do have issues that interfere with their relationships, even if only temporarily, and our job is to help them overcome their obstacles to relating well to others. When you have been practicing long enough, you may be tempted to reject a workable client who reminds you of someone who did not work well in treatment.

Once I received a call from a therapist out of town, asking me if I was willing to see a client of hers who was moving to the area. I asked a bit about this client, and the therapist reluctantly admitted that she had not made much progress. But she quickly added that this client, Debra, a student in her early 20s, was highly intelligent and could be endearing. The therapist tried to assure me that Debra had potential for

making progress in therapy. My gut reaction when I was talking to this therapist on the phone was that she was not being forthcoming. But I agreed to meet with Debra when she came to town to see if we were a match.

When I went into the waiting room to meet Debra for our first session, I extended my hand and introduced myself, as I normally do at a first meeting. She shyly looked down and offered me a very weak half-handshake. Her shyness was not a problem for me, but her exceptionally weak handshake triggered a negative response. As I inquired about her history of relationships, which is the only history I focus on early in treatment, she revealed almost no relationships outside her family. She had had three previous therapists and had been in therapy continuously since she was a teenager. I began to see a pattern of therapists serving as a lifeline for her. Because of her family's wealth, she could essentially pay therapists to keep her company. Always choosing someone psychoanalytic, she immediately set up multiple sessions per week, presumably to engage in the analytic process.

I was frank with Debra and told her I was concerned about therapy being a substitute for having relationships out in the world, rather than facilitating her ability to navigate successfully on her own. She assured me this was not the case. She just needed more time. Given her poor relationship history and my lack of genuine interest in her, I should have referred her elsewhere. I was influenced by Debra's reluctance to meet with other therapists, by the referral from a colleague anxious to get her situated with a new therapist, and by the fact that I had open hours. Since I did not have any strong negative feelings toward her, I agreed to treat her.

The first year of therapy with Debra went rather well. Since she presented as excessively fragile, she enjoyed the fact that I did not treat her that way. Her previous therapists had hesitated to confront her for fear of triggering her all-too-frequent suicidal obsessions. When she told me she felt like committing suicide, I asked her who she was angry with. Slowly, she began to get better. She made better eye contact with me, began to talk more herself rather than relying on me to question her, and she experienced a significant decrease in her depressive symptoms. Debra began to talk more with people at work, but still had no social relationships of any kind. She also started exercising, which made her feel better emotionally and physically.

However, as we moved into the second year, I noticed that she was no longer improving and, if anything, was becoming more depressed again. I attempted to understand this backward slide and engaged Debra

in conversation about it. Nothing had changed, yet she was inexorably sinking back into the passive-dependent, severely depressed mind-set that she presented with at the beginning. Her psychiatrist upped her antidepressants, but this had little positive effect. Debra regularly came to her Monday sessions and announced with an odd smirk that she had not exercised or had any social contact over the weekend. In fact, she had not left the house at all. I naturally tried every intervention I could think of to turn this situation around. But nothing worked. I finally asked her if her previous therapies had followed this pattern. She said they did. She also noted that she made much more progress in this therapy than she had in her other treatments.

"So the progress inevitably falls away and you return to the state in which you started?" I said.

"Yes," she answered. "I thought maybe this time would be different, but it isn't."

What struck me as particularly odd was that Debra said this without any emotion or any concern at all. She routinely displayed a slight smirk when she reported her self-defeating behaviors. Having been severely controlled as a child, she didn't let anyone get too close, and when someone was having a positive effect on her that was undeniable, she needed to negate that influence. After a great expenditure of energy on both our parts, I realized Debra was not really getting any better. I regretted having taken her on. I finally told her it was time for her to find a new therapist because I felt it was not ethical to continue treating someone who was not responding to treatment. She was upset, but resolved this situation by moving back to the city where her family lived.

I vowed never again to take on anyone who was so unengaged and unable to take responsibility for her own life. About 15 years later, a client I will call Rebecca, whom I discuss throughout this book, came to me for therapy. She had recently moved to the area and had done Internet research to find a good therapist. Having had a recent bad experience with a therapist, she wanted to choose her next one carefully. Rebecca found my name, Googled it, and discovered my writing and speaking engagements. She read some of what I had written and decided I was the best choice for her. She called and made an appointment. When I walked into the waiting room to meet her for the first time, I was taken aback by the sight of a 20-something woman who looked very much like Debra. They had the same withdrawn, passive demeanor, similar coloring and body shape—and the same difficulty making eye contact. They also shared a slow, almost shuffling depressive gait. My immedi-

ate reaction was: I do not want to treat this person. She is too much like Debra and I have no intention of repeating that experience.

As we settled in to talk about why she had come to see me, it became evident that she shared even more with Debra. They both had had numerous previous therapists, and both had been hospitalized for severe depression and suicidal ideation. Rebecca additionally had a history of cutting herself. I told her that I wasn't taking on clients who required after-hours phone calls and possible hospitalizations. I said I was leaving that to my younger colleagues, and would be happy to refer her to one of them. But she was persistent.

"But I like you, and having read some of your stuff, I think you would be the best therapist for me. I will not be too much trouble. I can manage and not make phone calls, and I definitely do not want to be hospitalized again."

I explained to her that it was not in her best interest to have to hide her untoward emotional events, and that it was unfair to her to expect that she could control whether she needed hospitalization in the future. She was better off seeing someone else. At first I thought she was fighting to get me to take her on simply because she didn't want to be rejected. But I gradually realized that she was not just like Debra. In spite of all they shared, they were also very different.

Moved by Rebecca's determination, I began asking other diagnostic questions, and discovered that she was able to maintain relationships, and had several long-time friends. She was also close to her family, especially a younger brother whom she felt protective toward. The way in which she differed most from Debra was that she did not hesitate to engage with me and to work to convince me that she was treatable. Her passivity disappeared when she needed something. Rebecca also displayed a witty, playful side, and even went so far as to humorously mock me for being so reluctant to treat her. I liked that. Moments later, I realized I liked her, and that underneath her passive, weak façade was a fighter. I agreed to treat her and, unlike my experience with Debra, this treatment has been one of the most successful in my career.

Clearly, past experiences and personal biases can color initial reactions to clients. But I believe therapists are much more prone to taking on people they do not feel good about than to prematurely referring those people out. Probably the biggest obstacle to referring someone elsewhere is how to broach the subject with the client without causing hurt feelings or discouraging that person from going into therapy. Keep in mind that if you know this person is not a good match with you, at some level the client knows it too.

The primary responsibility for assessing the match is the therapist's. If the therapist is not sure, she will naturally make another appointment and give the possible match some time. But if you know right away—and I think most people do—you can simply tell the client that you think he would work better with a colleague of yours. If you are working in a group practice, you probably have a coworker who might work better with the client in question. If you are in private practice, you have a myriad of choices. This process is made easier by telling the client up front that part of the purpose of the first interview is to see whether you are a match. If I think I am the wrong person to be treating a client, I may say something like, "Having heard about your symptoms and problems, I think my colleague Dr. A. is more experienced in this area and would be a better person for you to see."

Before I say something like this I have thought it over in my mind and tried to come up with someone who would work well with this client. Once I have given a name, or several if I can, I tell the client to feel free to call me if these people do not work out, and I will come up with other names. Sometimes this process occurs on the phone when the prospective client first calls, either because I have an immediate negative feeling about the person, or because she has a problem requiring expertise or experience that I do not possess. Although turning someone down for therapy is inherently anxiety-producing, it is better to refer out than to engage in a process that has little chance of being successful. Doing good therapy is challenging, even when the therapist and client hit it off and feel optimistic about the relationship. Both people deserve a reasonable opportunity to succeed rather than to fail.

FAILURE TO ENGAGE?

Barrett, Wee-Jhong, Crits-Cristoph, and Gibbons (2008) report that there has been no real change in the number of times a client sees a therapist. After a review, they found that 50% of clients drop out by the third session, and 35% end after a single session. Most clients do not attend more than six to eight sessions, which falls short of the recommended 11–13 sessions for a basic behavioral intervention. These figures apply to both institutional and private practice settings, and fee is not an issue: the same statistics apply when treatment is free. It appears that many clients are deciding after a single session (or the first few) that they do not wish to return. Given how difficult it can be to admit to needing help, taking the step of calling a therapist, and

then showing up anxiously for a first session, why do so few people remain in therapy?

Do clients determine on their own when they're poorly matched with a prospective therapist, and then decide to seek treatment elsewhere? Some may, but most do not, I suspect. To me, these statistics suggest that therapists need to do a better job of emotionally engaging new clients during the first session or two.

Though I urge therapists not to treat anyone they don't like and can't relate to, it is also true that those clients are not the majority. What about the clients who *are* likable enough and interested in therapy? Why aren't they staying in treatment longer? What happens, or fails to happen, during the first meeting that discourages them from returning?

Therapists experience anxiety at meeting a new person, just as anyone does. New therapists naturally feel more anxiety than experienced ones do. The question is, How do therapists manage their own anxiety at the prospect of meeting a new client and making the decision to work, or not work, with him? And are the affect-regulation methods for therapists adaptive—that is, do they work? Given the attrition rate of clients, it is safe to question whether they do.

Barrett et al. (2008) suggest that early termination is likely to be caused by either a failure to engage or a failure to address some deterioration or rupture in the therapeutic alliance. They acknowledge the difficulty, however, in pursuing negative feelings. They say:

> The process of recognizing and addressing weak alliances is difficult. For example, Regan and Hill (1992) found that both therapists and clients tended to leave negative things unsaid, particularly negative feelings. Leaving negative things unsaid is especially troubling because, in one study, therapists were aware of only 17% of what clients withheld. Even long-term experienced therapists were able to identify hidden negative feelings less than 50% of the time. (p. 256)

Clearly, therapist problems with managing affect, being uncomfortable with negative feelings, and even gentle confrontations with new clients make it more difficult to build the therapeutic relationship.

Another possible obstacle to building a strong therapeutic alliance from the beginning can be some of the traditional therapist behaviors that actually interfere with relationship building. Taking a history can be one of them. Hirsch (2008) prefers to allow the client's history to be revealed naturally during the dialogue with him or her. I agree, and suggest that note taking, turning to lists of prescribed questions, and spending large amounts of time on insurance forms and other paper-

work are obstacles to emotional engagement with clients. When someone comes to therapy he is usually in distress and nervous. Shaking hands when meeting new clients typically reveals sweaty, warm palms. Helping the client to become comfortable talking about himself is our first objective. The best thing we can offer is an opportunity for them to speak of their concerns as early as possible, and a demonstration of our ability to listen and be empathic. Unless we decide we cannot work well with a certain client, we need to help him overcome his fears of being vulnerable, weak, embarrassed, or ashamed.

First sessions are difficult for therapists too because they are often intensely emotional events, and we are unprepared for the impact an unknown person will have on us. Just as our clients fear that we will reject or not understand them, I think we unconsciously fear being overwhelmed by their anxiety, pain, or hopelessness. Over time we learn to adjust to our clients' displays of emotion. We develop a context for hearing and regulating our internal responses. But first sessions inevitably bring the fear of the unknown. Being aware of this fear before the first meeting can help therapists deal with the possibility of having strong visceral reactions and internally feeling slightly out of control in the presence of an emotional client. Anticipating countertransference emotions, and accepting them as natural, can aid therapists in keeping their attention focused on the affect-laden material the client is presenting, rather than distracting away from it with issues like getting a family history.

Note taking presents a significant hurdle because it disrupts the face-to-face contact and nonverbal affective communication that are vital to establishing a relationship. Therapists who take a lot of notes might want to pay attention to *when* they decide to write something down. I think they will find that rather than responding to the revelation of important facts in the client's life, they are responding to and trying to regulate their own internal emotional experiences.

PAYING ATTENTION TO WHAT THE CLIENT SAYS ABOUT HIMSELF

Clients usually tell you something essentially important about themselves in the first session, just as people do in all relationships. For example, one person jokingly says, "I told my girlfriend I'm a pathological liar, ha ha." In working with such a client, you will probably discover that he prevaricates a lot. Another client says, "I'm just no good at

relationships. They never work out for me." While I certainly wouldn't immediately write this person off, she is probably right and is telling her therapist that the therapy relationship will be troubled, at best. (I do determine prognosis on the basis of whether my client has been able to sustain any type of relationship over time. The inability to sustain a long-term relationship indicates a poor prognosis.)

Another client appears to be relatively healthy and high functioning. He may be well dressed, good looking, and articulate. Yet he casually mentions that he often thinks there is something seriously wrong with him mentally. He is probably right. Therapists want to see the best in clients and want to believe they can help them. But still, we ought to take what clients say about themselves seriously. Resist the impulse to write off what they tell you as simply an expression of low self-esteem or depression. It is more like a warning about what you are about to experience for yourself.

Clients' actions at the beginning of therapy are just as self-revelatory as their statements. The client who comes late, who sits as far away from the therapist as possible when offered the choice of seating, who is not just shy, but evasive—all of these behaviors tell you what to expect in the future.

In all fairness, the positive things clients say about themselves are also likely to be true. The person who says she mostly gets along well with others and is well liked is someone you will probably also like. The person who says he knows he has talent and will be successful—he just needs to work out a few things—is also likely to be right. All of us know far more about our present state and our likely future than we imagine.

THE THERAPIST'S IMMERSION IN THE CLIENT'S EXPERIENCE

One of the benefits of our profession is that it forces us to shake off our own everyday problems and small crises because the job demands it. Yet for beginning therapists, their self-consciousness and fear of failing may interfere with their ability to listen. Hill, Stahl, and Roffman (2007) report that new therapists "typically ask a lot of closed questions, give advice, disclose personal information, and talk a lot, as they would in informal helping situations with friends" (p. 365). Their research about novices, who reported their concerns through journaling, indicated that they were very anxious about being good therapists. They

reported problems with under- or overidentifying with clients; difficulties in directing the sessions, either pushing clients too hard or being too passive and letting clients ramble; and difficulty formulating good, brief interventions. This cumulative research on new therapists suggests they need more direction for handling clinical material, as well as increased self-awareness.

So how do you know when to intervene and when to be silent? I assume I should be as still and silent as possible once I have asked the opening question: "What brings you here today?" or "What can I help you with?" Most clients will talk the whole session without much intervention by the therapist. The occasional empathic remark or question may be needed to keep the narrative flowing, but not much more.

A very shy or frightened client may be more cautious and need more reassurance and prompting. But such clients make this known to us in short order. Although silence may have been overemphasized in the field years ago, I think it is underemphasized in many training programs today.

If a client asks you whether you understand what he is saying or feeling, be honest. If you don't understand, say so. Something like, "I'm not exactly sure what you mean when you say … " or "I can't tell for sure whether you are mostly sad or mostly angry about what happened" will clarify things for him. No client expects the therapist to be perfect. And being honest conveys a willingness to engage respectfully about his experience and admit when you are unsure about his meaning. If he speaks in half sentences or is so vague that you can not understand what he is trying to communicate, he needs to know this. Let him know you are giving him this feedback because it is important to you to understand him.

One of the most common errors new therapists make is assuming they need to speak more. A client seeking a response will pause and look at you or directly ask. Jumping in to show what you know, or asking too many questions too rapidly, is likely to result in keeping the client at the surface, rather than promoting an expression of emotion.

New therapists tend to believe they are supposed to solve the client's problem, and behave accordingly. Clients who directly ask their therapists for immediate direction or medications to soothe their distress naturally stimulate the therapist's feelings of responsibility. Nonetheless, working to calm the highly anxious client and help him talk about what is wrong is ultimately more therapeutic than attempting to quickly solve the problem.

I remain amazed at the relief clients experience simply by talk-

ing. Therapists may feel like they are doing nothing when they sit silently, allowing their natural emotional responses to surface and appear wordlessly on their faces. But if you think about how rarely this occurs in real life, you might appreciate how valuable it is to someone in distress. When telling problems to a friend or family member, most people quickly encounter the response of "Oh, yes, something similar happened to me." Then the listener proceeds to cut off that person's narrative and begin his own. A quiet, compassionate, involved listener is indeed a rare thing and will be duly appreciated by anyone seeking therapy.

GAUGING YOUR UNDERSTANDING

How do you decide when to speak, and where is a good place to start? Clients will tell you when they are seeking a response by stopping talking. They may look at you directly with a questioning look on their faces. Or they may directly ask if you are getting what they are saying. Brief, empathic statements early in therapy usually work well to facilitate the client's further exploration. A benchmark for successful listening that I have used for as long as I can remember is my client's affirming response of "Exactly" or "Yes, that's right" when I express my understanding of what he is saying or feeling.

In my first techniques class in graduate school, the professor had us interview and audiotape volunteer clients from an agency, choose 10 minutes from that audiotaped session, and transcribe it. We were instructed to construct two columns, with the transcribed client statements on the left and our responses on the right. This exercise was invaluable because I was able to "read" things I didn't know from simply being in the session. I had instinctively felt that the session had gone well and that I had understood my client's concerns. But reading that transcript was like being struck by lightning. It was suddenly clear where I had given a therapeutic response and where I had missed the boat. When I was dead on, the client responded quickly with "Exactly," "That's right," or some equally affirming phrase. If she said, "Kind of" or "I guess so," I knew I was slightly off. If she looked away, said nothing, or changed the subject, I knew my performance was off the mark.

What was especially revealing were the times I actually changed the subject due to my own lack of interest or defensiveness. My client's response surprised me: she did not give up. Within a few minutes, she returned to the same subject and gave me another chance to respond.

As my professor said then, which was confirmed by my subsequent experience, this is almost always the case. Our clients do not typically give up trying to communicate something important. They keep trying to elicit the response they need. From this early training episode, I gained a whole new respect for even the most disturbed client's resiliency. Understanding that my clients would always give me another chance was a great comfort. My anxiety lessened and I worried less about missing something important and ruining the therapy. The less anxious and worried I was, of course, the more emotionally present and attentive I could be.

I encourage new therapists to record their sessions because the results are so informative. Not only can we determine when our responses missed the mark, but we can focus on what was going on in the interaction between client and therapist that caused us to veer away. I can ask myself, "Why did I change the subject? What was the client talking about or what was I feeling toward him or her that disturbed me or failed to engage me?" A therapist who is courageous enough to see his or her own weaknesses can gain substantially through this type of rigorous self-examination. Knowing that facing your own pain and weakness can only make you a better therapist serves to motivate therapists to face themselves. Seeing the moments that you understood the client and gave him profound relief or insight helps make the self-evaluation process gratifying as well as sobering. Establishing a pattern of examining the *interaction,* rather than the client, opens up a new world to discover.

BASIC EMPATHY

Most students of psychotherapy become familiar with the basic concept of empathy early in their training. They practice rephrasing other people's statements, focusing particularly on the emotion that is direct or implicit. Higher levels of empathy require transcending the parrot-like responses practiced by new trainees, integrating observations of the client's body language, facial expression of emotion, and the implications of the client's expressed thoughts. When the client is in denial, or feels guilty about his emotions, the therapist's ability to reflect what he is really feeling can be extraordinarily liberating.

Occasionally, some clients reject the therapist's expressions of empathy (McWilliams, 2004). It seems illogical that some people reject empathy, and it certainly makes the task of the therapist substantially

more difficult. Clients who actually become prickly and irritable in response to empathy cannot acknowledge any weakness or pain, as it makes them feel inferior. For these people empathy equals pity, and no one wants to be pitied. So empathy must be titrated—given in small, incremental doses.

Rebecca, whom I introduced earlier in this chapter, said she chose me to be her therapist after interviewing several others, and because I didn't have "the therapist voice." When I asked her what she meant exactly, she imitated a person being overly solicitous in a low, soothing voice that obviously smacked of insincerity. She was of the opinion that many therapists were patronizing in their approach, creating an instantaneous one-up position with their clients. She said she didn't need a therapist whose emotional tone was the equivalent of "poor baby." She wanted a more respectful, egalitarian relationship. Moreover, because she was emotionally reserved, she preferred empathic statements that were not too emotional in tone.

It can be difficult to predict which clients will reject the therapist's attempts at conveying empathy and understanding. Some clients who are narcissistic or borderline not only want empathy, they may complain bitterly if it is not forthcoming in large doses. Diagnosis does not necessarily predict who will accept or reject the therapist's empathic responses. Most clients will let the therapist know quickly what he or she *experiences* as empathy versus what the therapist *intends* as empathy.

For example, when Rebecca described how her mother would insult her and verbally abuse her at times, I said, "That must have hurt your feelings." She replied unenthusiastically, "Yes, I suppose it did." Then I said, "And made you angry." She immediately said that she was not aware of being angry, and turned her body away from me. She said that, after all, her mother only derided her when she had, in fact, disappointed her in some way. Her mother was entitled to her feelings. She was definitely *not angry with her.*

As we spoke further it became evident that she blamed herself for any mistreatment at her mother's hands. Blaming her mother would have interfered with her endless longing for a loving relationship with her. Therefore, any empathy that involved reflecting negative feelings Rebecca had toward her mother was rejected out of hand. It can be confusing to a new therapist when accurately understanding and mirroring what her clients are feeling is responded to negatively.

A client may reject our empathy because it is inaccurate (misplaced), or because it is accurate, but makes him or her uncomfortable.

I mentioned earlier that we should look for affirmation from our clients that our responses are accurate and helpful. Doesn't the empathy-rejecting client contradict this general rule? Yes and no. When the therapist simply misses the mark, the client's response is lukewarm or mildly negative. As I stated earlier, failing to get the response they are looking for, some clients will just change the subject or look away in silence. However, the client who feels anxious, guilty, or humiliated by empathy has a strong defensive response that cues the therapist that she has hit a nerve—and that doing so is not welcomed by the client.

So what does the therapist say to the client for whom empathy can feel like a spear rather than a balm? From my experience, the fewer words the better, and the less dramatic the better. Saying something like "That must have been difficult for you" is often quite enough, even when the client has been severely traumatized. It will not be lost on her that you are listening, asking questions, encouraging her to say more, and registering empathic facial expressions. With this type of person, less is more.

The rare client who routinely rejects even the most minimal empathy has a poor prognosis. One woman I treated could not articulate any real emotion other than anger (alexithymia). She responded to my statements of "You seem sad" or "You look angry" with sarcasm, often turning my comments back on me and asking if I was sad or angry. I found this practice quite irritating and grew weary of trying to verbalize what she seemed to be feeling. Clients who perceive almost every encounter as a power struggle have serious problems with basic trust and rarely make themselves vulnerable enough to change.[1]

EXCESSIVE DEMANDS FOR EMPATHY

Nancy, a client I saw for several years, clamored constantly for expressions of exaggerated sympathy—even pity. When these were not forthcoming, she became angry and accused me of withholding and being cold. Nancy had been traumatized as a child, both emotionally and physically, and had not learned how to interact with others in a healthy way. Her mother was domineering and controlling. For some time Nancy was oblivious to the same traits in herself. Because her demands

[1] I documented this case in my book *Seduction, Surrender, and Transformation: Emotional Engagement in the Analytic Process* (Maroda, 1999). The treatment was mildly successful, but ultimately ended in impasse over her desire for physical contact.

took the form of asking for comfort and sympathy, she was convinced that her expectations were reasonable. She became indignant and self-righteously angry when she did not get what she wanted.

For example, Nancy routinely complained about her husband and held him responsible for her feelings. If she had a hard day at the office, it was his job to know this when she walked in the door. She expected her husband to do an immediate empathic "read" on her, even if she had not spoken a word. If he failed to notice her distress, or failed to immediately focus on relieving it, she accused him of being insensitive and unloving.

Whenever Nancy finished her litany of complaints about her husband, I did not feel sympathetic toward her. In fact, I usually felt bad for her husband, wondering how he tolerated being held responsible for Nancy's feelings throughout their long marriage. My lack of empathy was not lost on Nancy. She often looked me right in the eye and asked me to say something. I usually said something like "I can see you are really upset and wish that your husband could take away your pain." She would then respond, "That's all you have to say? I tell you how absolutely terrible I feel and you sit there calmly and say you can see I'm upset?" I asked, "What would you like me to say?"

As she did with her husband, Nancy illustrated for me exactly what she expected. She said, while adopting a facial expression of exaggerated sympathy, akin to what mothers of young children might do with an injured preverbal child, "Awwww, I'm so sorry that you are feeling so bad. That's terrible." As she said these words she motioned in the air as if giving someone a comforting pat on the back. I said, "So that's what you really want me to say and do?" And she answered, "Yes."

I proceeded to tell her that I couldn't possibly do that, both because it was condescending—more like pity than empathy—and because it would be emotionally dishonest on my part. She said she didn't care. She wanted it anyway—because that's how she had defined caring and how she responded to her husband and children when they were upset. Was it really too much to ask?

I have this client's permission to write about her and plan to discuss this case throughout this book, but I think this example illustrates some of the complexity involved in doing therapy and how therapists can find themselves in a quandary when the client wants something we cannot honestly give. Nancy's pain was real, and she needed me to understand that, yet I could not give her the type of response she demanded. What I did was explain that I had no interest in feeling sorry for her, but that I understood that she experienced significant pain on a

regular basis and was frequently inconsolable. Gradually, as she could tolerate it, I introduced the idea that she was convinced that someone could rescue her and take away her pain. As a result, she placed responsibility for her feelings on others—chiefly her husband and me.

ASKING QUESTIONS[2]

A truly interactive treatment relies on the skill of the therapist to tease out what the client may be hiding—even from himself. A good therapist is a lot like a detective. You keep looking for clues everywhere, and do not hesitate to inquire further, even when the topic is potentially embarrassing or uncomfortable for you and the client. New therapists may be reluctant to be this direct. The tentative new therapist may respond to the client's reluctance with reluctance of her own, creating an unproductive mirroring. If the therapist's inquiries are ignored or rejected, the therapist can simply move on. However, failing to pick up on something that the client is afraid to reveal can translate into a stalled or incomplete therapy.

I was struck by Farber, Berano, and Capobianco's (2004) report that clients were not sufficiently aware of the expectation that being forthcoming was part of their role in treatment. I have found that even in psychoanalysis, where free association is encouraged, clients only tell their secrets when they are ready to do so. Impediments to being more transparent include guilt and shame over feelings and behavior. Clients may drop an occasional hint as to what they are omitting and wait for the therapist to notice and bring it up. Farber et al. report that in their study "over half the participants wished their therapist would pursue their secrets more actively" (p. 343).

The following case example illustrates the notion of the client who comes with a secret, with varying degrees of conscious awareness. Jennifer, a college student, came for therapy because she realized she could not marry her high school sweetheart, and was guilt-ridden and suicidal over the thought of ending the relationship. When someone is suicidal over *ending* a relationship, rather than suicidal over *being*

[2] Casement (1985), Langs (1978), Hedges (1983), and others have covered the broad and very important area of active listening admirably, so I will not delve into it here. Langs's work on manifest and latent content is particularly valuable because it teaches therapists how to identify the client's unconscious references to both himself and to the therapist. Stern (1997), McWilliams (2004), and others have written on the importance of curiosity, and I can't agree more.

left, there is almost always something else going on pertaining to that person's ability to maintain a relationship. Upon further questioning, Jennifer said she felt like a terrible person for being with her boyfriend for years, basking in his love and acceptance, and then "dumping" him. Wasn't she a terrible person for doing this? How would she ever find love? What would become of her dreams of finding Mr. Right and living happily ever after?

The first few months of therapy centered on listening to Jennifer and helping her to manage her guilt and anxiety. Her family had been dependently enmeshed, which was the root of the separation anxiety and guilt Jennifer experienced over breaking up with her boyfriend. She had never really separated from her parents, and her guilt feelings were due to her belief that separation meant abandonment and lack of love. She came for sessions twice a week, began to feel better, and managed to go through with the breakup even though it was effortful and painful. Once that was done and she settled down, we could start working on her internal emotional issues.

I had the sense that Jennifer had issues she was not addressing, but her emotional crisis over ending her relationship left little room for anything else. As she recounted the details of how things had deteriorated between her and her boyfriend, she sadly noted that her interest in him had been declining for some time. Here is an example of a simple restatement of the client's position that might be taken at face value. *Her interest in him had been declining for some time.* The meaning seems obvious, and in a sense it is. But a therapist is looking for more than the obvious meaning. Our job is not just to understand what the client is saying, but to help the client to explore issues that are threatening to her, may be threatening to us, and lie just beneath the surface, waiting to see the light of day. We get to these issues frequently by asking simple questions in response to simple statements.

In this case, I asked, "What did you experience that let you know you were losing interest?" Jennifer brightened up at this question, eager to explore this issue more fully. (Had she brushed off the question or changed the subject, I would not have continued.) She said that she was much less interested in sex, and often didn't want to go to bed at the same time as her boyfriend. She stayed up and surfed the Internet instead of joining him. I asked her what sites she went to. She blushed and said she often went to soft porn sites. I noted that she was interested in sex, but not sex with her boyfriend. She agreed and seemed relieved that I did not express any shock or disapproval about her interest in looking at nude pictures. I asked her about what kind of nudity

it was, and she replied that she looked at pictures of naked people and some sexual scenes, but nothing kinky or weird.

I want to note here that Jennifer was not reluctant to answer my questions, but she also did not volunteer anything that wasn't asked. So I asked another very important question that I almost always ask when any client mentions looking at sexual pictures or films, or mentions having sexual fantasies. I ask what the preferred scenario is. Who is in the "picture" and what is happening? My focus is not on graphic sexual material, but on the characters and the emotional scenario being played out. Jennifer replied that she liked watching people who had really nice bodies kissing.

I noticed that she had used the word "people" several times, avoiding any direct reference to men or women. So I asked her *who* was kissing in these scenes. She blushed again and said, "Oh, you know, lots of different people. Men, women, occasionally groups." Then she looked away. "Anything else I should know?" I asked. She replied, "Well, I look at women a lot." This was the first time that Jennifer had made any reference of any kind to being interested in women. When I asked her about women she reluctantly admitted that she had been looking at women more and more and would spend hours online doing so after her boyfriend went to bed. She found scenes of women kissing to be very arousing.

I was cautious during this questioning, which took a half hour or more, because I didn't want to threaten her by probing too deeply into what was a delicate issue for her. I wanted Jennifer to feel safe talking about it and know that I would treat her interest in women as calmly and matter-of-factly as I would treat her interest in men. I asked her if she had ever had any sexual experiences with women or with girls when she was younger. She answered that for a couple of years she and another girl would occasionally lie on top of each other and rub their bodies together. These episodes began when she was nine years old and ended when the other girl's mother walked in on them one day about 2 years later.

She reported engaging in sexual exploration with another female friend a few years later. I asked her if she knew this was sexual at the time. She said she did, but just wrote it off as early adolescent curiosity. I asked her what she thought about her current interest in women. She said she definitely was not a lesbian and really didn't know what to make of it.

Jennifer had been in therapy for a couple of years prior to coming to me. I asked if she had explored this issue with her previous thera-

pist. She had not. When I asked why, she said it had simply never come up, and I believed her. She let me know early in the treatment that she felt much safer with me than with her previous therapist, who would extend the sessions when Jennifer was upset, and one Friday night talked to her on the phone for 3 hours. In fact, the poor boundaries of the previous therapist made Jennifer uncomfortable and illustrates how boundary maintenance impacts every aspect of treatment.

I think it is important to keep in mind that sensitive issues like sexual orientation are often hidden and can remain buried over the entire course of therapy if the therapist does not ask the right questions. If there is any magic in what we do, it is in our ability to bring important issues or feelings to the surface that have caused the client anxiety, shame, guilt, and confusion. Working to keep such matters out of consciousness is tiring and burdensome. Most people cannot get to these issues and explore them on their own. Perhaps that is why Freud likened psychoanalytic exploration to an archeological dig. (Jennifer surprised me one day by saying she had met and kissed a woman, and from that point on we worked through her difficulties in accepting her homosexuality. She eventually met and fell in love with another young woman and they moved in together.)

The therapist has to be fearless, in a sense, to pursue the material that the client is not readily talking about. Often a client's discomfort adds to the beginning therapist's anxiety, and the matter may be prematurely closed so they can both be more comfortable. I encourage new therapists to be brave and persevere when they believe they have tapped into something important that the client is reluctant to discuss. If the client refuses, or becomes defensively angry, it is a simple matter to take that cue and wait until she is ready.

SETTING GOALS

Behaviorists see setting goals as essential for defining the purpose of the treatment, establishing a cooperative, focused relationship between therapist and client, and evaluating the outcome. Psychodynamic clinicians have been slower to recognize the need for goals, preferring to believe that insight and understanding would either be enough or would naturally lead to needed change. The tide is turning, however, and analysts like Renik (2002) have been calling for psychoanalytic clinicians to embrace both goal setting and elucidation of technique.

Given the evidence for the therapeutic efficacy of goal setting, goal

revisiting, and shared goals between therapist and client, there is no logical reason for not setting them. Even analysts who may share with their clients the general goal of achieving greater insight and understanding will benefit by stating that goal at the outset of treatment.

Goals often change as the therapy progresses, of course, and depend on how long it lasts. The goals for a 10-session treatment of depression will differ from the goals for a several-year psychodynamic treatment. Sometimes a client intends to stay only for symptom relief but changes his mind when he discovers that more is available to him. Symptom relief is a great place to start, and few clients will complain if their therapist says something like "So it seems that what you are wanting from therapy right now is help in relieving your depression." If the client agrees, then the therapy proceeds, usually after a discussion regarding the appropriateness of medication.

As the therapy progresses it is natural for new goals to appear. Again, the length of treatment remains a mitigating factor. Once a client's depression has lifted, he may be interested in talking about realizing his potential, wanting to improve his social skills, or becoming more fit and healthy. (I always encourage my clients to exercise, especially if they suffer from depression.) Setting goals enhances the therapeutic alliance and reminds both participants that they are working together on a defined project, each with their own responsibilities. Realistic goal setting aids in grounding the therapy project in the real world.

As the therapy continues, we typically revisit the goals, particularly when my client reports feeling better or having made significant progress in an area where a goal has been set—for example, becoming more assertive, expressing emotion more freely, or being more self-aware. Evaluations can be formal or informal. For myself, I find that the topic of goals comes up naturally as does everything else that is important. My client may say he is frustrated and doesn't feel like he's getting anywhere—what do I think? Or he says he feels different inside and knows he is far from the person he was when he began therapy. That's my cue to note what I have observed that confirms his progress. In this way, evaluating therapy flows naturally. But it is just as useful, and certainly not harmful, to set up a time frame for regular evaluations. If a client feels the intervals are too short or too long, he will let the therapist know and changes can be made.

As I stated previously, there are always exceptions to the generalities I describe here. While clarifying what my client wants from therapy and defining realistic goals has worked well with everyone I have treated, evaluating those goals may be a different story. The client

I mentioned previously, Rebecca, who did not want me to acknowledge her anger at her mother, also hated any reference to her improvement—even simple symptom relief. So I learned to stop saying anything about it and just note it silently.

One day I said, "So you seem to be feeling much better lately. Is that true?" She looked at me and said, "Don't flatter yourself. Yes, I'm feeling a little better, but it's not because of you, it's because of my boyfriend." Control was a huge issue for Rebecca, and she loathed and feared the possibility of anyone having any power over her. She was reluctant to admit to having any attachment to me or that working with me was benefiting her. We had established goals. She knew them. I knew them. So I just forgot about regular evaluations because, unlike most clients, for her they were not helpful. She could be quite assertive and always let me know when she was unhappy with a session or something I said, and this is how we stayed on track. Again, the operative policy is listening to what a client needs and responding accordingly, while remaining flexible enough to adjust to the complexities of each individual and each therapy relationship.

DEALING WITH THE LULL

A new client may have begun therapy filled with emotion, perhaps crying copiously in the first few sessions. Her therapist had been empathic and effective in helping her to tell her story and feel relief. This relief came after a brief period, anywhere from two to 10 sessions. One day she began her session by saying, "I feel much better. And I am not sure what to talk about today. There's really nothing new that's happened. Can you give me some direction?" Not all clients do this, but many do. Without the pressure of an emotional crisis they suddenly become self-conscious and concerned about how to proceed. Should they keep talking about the same issues, or will that be boring and unproductive? They may say they have several things they could talk about, but don't know what to select. How do they know what is most important?

There are no rules for dealing with what a colleague of mine (Brian Smothers, personal communication) calls "the lull," but generally clients are looking for some education about the therapeutic process, asking what to address and what to expect. Some clients may actually have nothing more they wish to pursue and will leave at this point. Others will want to stay and go deeper, but are unsure of how to proceed.

I usually assure my clients that they needn't worry about being

repetitive. I tell them that we all have a certain set of problems that we revisit constantly and that the therapeutic process is about depth, not breadth. Working through and gaining insight, learning to manage feelings, strategizing new behaviors—all require revisiting the same basic issues.

If my client does not know which of many topics to discuss, I always advise him to choose the one that will produce the most feeling. I educate and enlist him in this regard on a regular basis. If he asks me to tell him more about how therapy works and what he can expect, I am candid regarding both the potential gain and the potential pain. Even shorter treatments aimed at symptom relief require the experience of emotion for lasting effects. Longer-term treatments with more complex goals like removing blocks to achievement, significantly improving affect management, and altering patterns of relating usually require periods of deep pain.

I explain that change begins with the letting down of defenses, or emotional "surrender" (Maroda, 1999), and then I talk about that particular client in terms of her history and what type of emotional experiences she is likely to relive in the therapeutic process. I talk about this subject more in Chapter Six, but I let my clients know that what they defend against feeling is exactly what they need to feel to get better. I am not quoting the literature here, but rather expressing what therapists know from experience. Paraphrasing Winnicott (1974), I say that we always fear most what has happened to us already. Our greatest fears revolve around reexperiencing the most painful moments in our lives, whether we realize it or not.

"Lulls" can occur at any time and may appear frequently with some clients. The important point for therapists is that they need to work to get the process moving again. It may be tempting to respond to the client's lack of direction or pleas for assistance by taking responsibility for the session. Asking questions like "What could you talk about where you would feel some emotion?" or "What thoughts or events or dreams have occurred since your last session that stimulated some feeling in you?" places responsibility for generating material on the client rather than the therapist.

SUMMARY

Beginning therapy can be a daunting event for both therapist and client, as each attempts to be emotionally present and responsive. Viewing

therapy as a relationship requires therapists to examine their own emotional histories and patterns of attachment as they embark on the therapeutic endeavor. Understanding mutual influence and the importance of affective communication can facilitate the therapist's self-awareness and help him or her make good clinical judgments in the moment. The first assessment involves deciding whether client and therapist are a good match. Once therapy begins in earnest, the therapist listens carefully, tracking the client's line of thought and feelings. Assessing the impact of each intervention places the emphasis on what is happening within the therapeutic relationship. Using the client as a consultant removes the therapist from the burdensome position of attempting to navigate the relationship through independent, authoritarian decisions. Rather, the therapist combines legitimate authority for maintaining proper boundaries with following a course jointly determined by therapist and client as they work together.

2

Mutuality and Collaboration

Influencing Each Other

> It is usual for therapists to see themselves as trying to understand the unconscious of the patient. What is not always acknowledged is that the patient also reads the unconscious of the therapist, knowingly or unknowingly.
>
> —Patrick Casement (1985, p. 3)

Since most clients do not remain in therapy beyond the first few sessions, many new therapists are understandably relieved and validated by the client who keeps coming back, lets down his defenses, and is eager to pursue the illusive process of change. What happens next? In Chapter One I spoke of the critical importance of setting mutually agreed-upon goals, and recognizing how these goals will change and be reshaped over time. Some will be jettisoned as unrealistic or unwanted. Others are likely to be added if the work continues and goes deeper.

But what about the process itself? What really happens within the therapeutic dyad as they work together doing psychotherapy? New therapists often experience renewed anxiety once a client is won over and remains in treatment. Both therapist and client feel a sense of excitement but also wonder, "What is supposed to happen now?" Direct instruction in these matters is almost nonexistent. Even when training is completed, many new therapists have not had the experience of seeing anyone more than 10–20 times. Seeing clients in a training situation also veers from reality because the client is often all too aware of the

therapist being evaluated. As a result the client will often work to make the therapist look good, especially if he is being seen for a low fee.

After completing training, new therapists confront the challenges of working with clients in the real world, sometimes with supervision, other times not. At some point in time they find themselves in the throes of strong emotional reactions, not only from their clients, but within themselves. Both therapists and clients can be overwhelmed by confusion and anxiety. Why are all these feelings emerging? And who at any given point in time is directing the emotional course of the relationship?

Regressed clients, especially those with a history of trauma, can swing wildly between idealized love for the therapist and accusations of incompetence and callous disregard. The therapist often feels no differently toward the client on one day versus another and cannot understand what precipitated this radical change in attitude. Often just as inexplicably the same client will return for the next session and behave as though her angry tirade from the session before had not even occurred.

The client may demonstrate an uncanny awareness of the mood and even the life circumstances of the therapist. Therapists today are trained to deal with their clients' symptoms and may possess only the most basic sense of what it means for a client to repeat past patterns of relating within the therapeutic relationship. The inevitability of the therapist repeating his own past is rarely discussed in depth, even in psychoanalytic training. Rather, the emphasis is on ubiquitous, specific countertransference reactions, like irritation, boredom, anxiety, or affection.

BOTH CLIENT AND THERAPIST REPEAT THE PAST

Breaking from tradition, I want to emphasize how each person reenacts his or her past in the therapy setting to some extent—even in briefer therapies. The longer the treatment, and the deeper, the more likely both persons will experience a lengthy period of being engaged in recreations of their pasts. The essence of the therapy becomes working through these entanglements. And this working through necessitates consulting with the client throughout the therapeutic process, as well as self-reflection and possible consultation outside of the therapy. Casement's quote at the opening of this chapter expresses the essence of

mutuality: the client and the therapist know each other unconsciously and respond out of this unconscious knowledge. (This truth is confirmed by the neuropsychology literature, e.g., Dimberg, Thunberg, & Elmehed, 2000). Through this knowledge they mutually influence and shape the relationship.

One of the therapist's responsibilities is to help the client know and understand how he acts out of past experience, and how this colors his view of the present. The client will also be noting the same in the therapist. He may or may not verbalize this knowledge, depending on many factors, including whether or not it is conscious or unconscious. The client who *does* regularly observe his therapist and verbalizes these observations is perhaps the most challenging of all. No matter what the client's motivation may be for making these observations, the new therapist is likely to be surprised, unnerved, and defensive in the face of the client's ability to read him.

Again, training programs of all ilks fail to address the emotional realities of doing therapy. Behavioral approaches tend to focus heavily on giving homework assignments and "selling" the client on working to change his behavior. Sometimes this works fine. But too often the client returns not having done the homework and not having made any behavioral changes. He may have been too depressed to change. Or he may need to know how the therapist will react to his being a disappointment.

Relational psychoanalytic approaches accent mutuality and the uniqueness of any single therapist–client pair. Theoretically, at least, they are believed to be creating a new, unique relationship. Therefore emphasis on the client's old ways of relating is considered to be unproductive and pejorative. I find both the basic behavioral and the basic relational approaches to be lacking in recognizing how *both therapist and client will inevitably repeat past patterns of feeling and behaving*. Neither therapist nor client come to the relationship without personal histories and identities. More often than not the client clearly states she is seeking therapy for the purpose of changing old, unadaptive patterns. She may say she knows what she needs to do, but no matter how hard she tries, she ends up failing. Ultimately she reverts to her old ways and feels like a failure.

In saying this, I do not deny the uniqueness of each therapist–client pair, but rather emphasize how a good therapy relationship succeeds because it *does tap into old ways of feeling and behaving.* We know from the literature on emotion that affect patterns are laid down in the brain early in life and remain fairly constant (Schore, 1994). In *Seduction, Sur-*

render, and Transformation (Maroda, 1999) I devote a long chapter to the details of how these affect patterns are established; how they are recalled quickly by current stimuli; and how the stimulation of emotion is essential to the therapeutic process. I also note how the original neural pathways are never erased. Rather, parallel, new pathways are introduced by repetitive new ways of thinking, feeling, and behaving. Through this process the client both remains the same and changes.

I believe the best working hypothesis for any therapist is that any strong, repetitive pattern of thinking or feeling is rooted in the past. However, the stimulus for the emergence of some established way of feeling and thinking occurs in the current exchange between client and therapist. This precipitating stimulus may be difficult, even impossible, to discern at any given point in time. But it is there. The relational perspective invites us to think about our participation in these reenactments. However, I think most relational thinkers do not go far enough in recognizing the extent to which past patterns can be identified and worked with productively, rather than used to pigeonhole the client.

I see the therapy relationship as an organic, ever-changing entity consisting of a constant interplay between the client's established ways of being, the therapist's established ways of being, and the emotional encounters between them that generate change. Although the verbalized emphasis is rightly on the client's experience, the therapist is ideally willing to be open and candid about her own contributions to what is happening in the room.

IDENTIFYING PATTERNS OF RELATING

Hirsch and Roth (1995) reiterate Sullivan's (1953) belief, which states that the aim of treatment is helping the client to know and see himself as others do. Wachtel (2007) talks about working with the patient from the *inside out and the outside in*, referring to how the client sees himself, how he is seen by the world, and how he also constructs an external world that fits with his past experience and future expectations. It is the therapist's responsibility to gain an understanding of how his client has behaved with others and also to understand how he himself has tended to behave and feel, both with clients and in his personal life. A priority of the therapy, of course, is helping the client to see himself clearly and realistically. It will surely be difficult, if not impossible, for a therapist who has not had his own personal therapy to fulfill this role.

Clients who describe their past relationships as ending with aban-

donment, for example, will expect and train the therapist to abandon them. They will disappoint, criticize, express hopelessness, and sometimes be ungrateful. They will ultimately create a situation in which the therapist wants out and struggles to remain engaged. If the therapist has struggled with abandonment herself, she may be too quick to reject and distance from these troubled clients, or may guiltily overcompensate by absorbing blow after blow without wincing. I will discuss later in this volume how this latter response only frustrates clients who court disapproval and rejection, requiring them to up the ante.

THE THERAPIST'S REPETITION OF THE PAST

Adding to the complexity, every therapist has her own emotional themes that will be relived with clients during deep engagement. Being aware of these countertransference patterns is essential to doing good therapy. I realized fairly early in my career, once I established deep relationships with my clients, how my own primitive fears and wishes surfaced as well as theirs. I began to notice leaving the office at the end of the day feeling sad, or anxious, or optimistic and excited, often without actually knowing why. I felt overwhelming tenderness for some clients and rage at others. Generally speaking, I found seeing clients all day to be emotionally overstimulating. So I began my own psychoanalysis. Gradually, I came to a basic, although necessarily incomplete, understanding of why I reacted as I did.

One client engaged me in comic playfulness and reminded me of some of the best moments with my mother or sister, who were highly verbal and humorous. Another client berated me for my lack of skill, igniting the insecurities of my youth. Yet another was seductive with me, flattering me and affirming my need to be found attractive. At other times it was more difficult to find the source of my emotions. I began to appreciate the reality of unconscious-to-unconscious communication when after a seemingly uneventful session, I felt inexplicably and profoundly sad.

After doing therapy for many years, and beginning to write about what I did, I noticed there were themes running through my case examples. I discovered the same thing when I read the literature. Particularly in books where many case examples appear, I easily observed other therapists' repetitive themes. Try this out yourself and I believe you will see what I am referring to. One therapist author in particular alerted me to this phenomenon because her book's theme was so intense and

singular in its focus. Even though the book was *not* about eroticism, she described almost every client, male or female, as being seductive toward her and finding her sexually attractive.

Having met the author of this book, I knew she was not a striking beauty. She was meticulous in her appearance, but not someone who was magnetically sexual. It seemed highly improbable to me that so many clients were focused on the physical attributes of this then middle-aged woman, regardless of the myriad problems they brought to therapy. Only then did I realize she must have been unconsciously seducing them. This was her relational pattern. She was validated by being found sexually attractive, and in a sense, required it from the clients she worked with. Unfortunately, she proceeded to label their erotic transference as resistance. To me this was an instance of a therapist making her clients crazy (Langs, 1973) through enacting her own disavowed need for gratification and validation.

Similarly, I observed a different, but equally compelling, pattern of personal responding in a book written by a therapist famous for his work with difficult clients. I noticed he had an uncanny knack for making them so furious that several of them threatened to physically harm him. By his own admission, he frustrated their every attempt to get any type of emotional response from him until he finally lost control and blew up at them. Then they experienced relief, and so did he. In this instance I believe he made them more miserable than they needed to be, but in the end gave them the emotional feedback they needed, and they got better.

More recently I read a book by a colleague who openly talked about his competitive strivings with rich, successful male clients. He was very aware of his own vulnerability in this area, and used this awareness to work as productively as possible, rather than denying the implicit power dynamics. Instead of finding ways to undermine their success, he allowed himself to feel his envy and own insecurities and be aware of when he defensively felt either inferior or superior.

In examining my own case reports, I discovered some of my patterns of repeated feelings or behavior. Early in my career I tended to tilt the relationship in the direction of me working harder than most of my clients. I took too much responsibility for what happened in the sessions, then felt martyred and unappreciated. Once I felt unappreciated, I invariably found a way to make my clients feel guilty and bad about themselves. After repeating this scenario, and receiving feedback from my clients about being hurt by my subtle expressions of disapproval or exhortations to try harder, I began to realize how I needed

to change. No matter how much was accomplished, we both shared a certain sense of failure. And I was creating this outcome.

I also have difficulty with clients who immediately want to overpower me. I was dominated consistently by an older sibling when I was growing up and have a strong aversion to being approached initially in this manner. (More of my own vulnerabilities will become evident in the case examples I provide throughout this volume.)

What I have described here are brief generalities, but I hope they illustrate my point. All therapists bring their own history and expectations to the therapy situation, and to some extent will reenact those patterns of feeling, behaving, and expecting throughout the therapy. Not only do our clients train us to respond as their caretakers did, to some extent we train them to respond to us in familiar ways (Wachtel, 1993, 2007). Although I think it is impossible to eliminate these repetitive scenarios, it is possible to identify and work through them. Either the therapist or the client may be the one to initiate this process. Also, if we, as therapists, are aware of our own repetitive relational patterns, we are in a better position to respond to our clients' rejection when we try to fit them erroneously into our view of the world.

In my opinion, a great deal of what makes for a good match is a complementary and desired matrix of mutual influence. In a broad sense, the client and the therapist must have compatible forms of relating and attaching. They must match up in critical areas, complement each other in others, and optimally frustrate each other. For example, a client who cannot bear closeness will probably not match up well with a therapist who chose the profession to meet her intimacy needs. Just as with friendships and romantic relationships, I think the most successful therapist–client pairs share many of the same basic values, often have a similar emotional makeup, but express themselves differently. One is an introvert, the other an extrovert. One is a morning person, the other is not. One is very social, the other likes more alone time. Yet in a successful relationship they share enough early experience to allow for a strong connection. If either one frustrates the other in this basic human connection, the relationship fails.

For myself, I always ask myself at the beginning of each new therapy what I am aware of thinking and feeling in relation to my clients. Why do I want to treat this person? I must see this as a potentially gratifying situation or I would not have agreed to treat him. How do this person's feelings or needs resonate with what I feel or need, what I enjoy or don't enjoy? What do I have to offer or not offer this particular person? Have we experienced similar sorrows or fears? To what extent

do we share the same dreams and desires? In what ways am I comfortable with this client? Where is my anxiety, if it exists? Do we seem to speak the same language, even if our outward displays are very different? What makes me think I can make a real emotional difference (Buechler, 2008) in this person's life and how do I plan to do it? Allowing a free flow of thoughts and feelings as I meet with someone for the first time helps me to make the best decision I can regarding whether or not we are a good match.

ESTABLISHING THE COLLABORATIVE RELATIONSHIP

Once a client and I have mutually decided to work together, I begin to educate her about the process. Sometimes it happens all at once because the client is practical and immediately wants to know what she can do to facilitate the therapy from her end. With other clients who need several sessions just to express their current symptoms and concerns, education on the process comes a bit later. The timing for this type of conversation is not exact and can happen in snippets over the course of several sessions. But it should occur early in the therapy.

I let my clients know their role is not a passive one: they are active participants in the therapeutic enterprise. If they ask me to start the sessions, I explain why it is important for them to do so, focusing primarily on the issue of emotion. I cannot possibly identify what issue carries the most emotional valence for them at any point in time. I can raise certain issues that have been important in the past. But the task of knowing what is emotionally important in the moment is theirs. I also emphasize that it is important for them to take responsibility for the content of their sessions. My role is to guide and facilitate, not to determine what is important.

I may proffer possible topics to think about if the client is anxious and draws a blank—as sometimes occurs during what I referred to in Chapter One as "the lull." But my suggestions always center on those topics that refer directly to the client's experience, such as any thoughts or feelings about the last session; thoughts, feelings, or events *since* the last session; and feelings about coming to the session today. I educate my clients about the process, explaining how change occurs through the experience of emotion, so when they are deciding what to talk about on any given day, they should ask themselves which topic will produce the strongest feelings.

I encourage them to let me know how they are feeling about their therapy, either specifically or generally; to feel free to give me feedback about anything I have to say to them; and to let me know if we are off-track in any way. I tell them I am responsible for directing the therapy and maintaining the boundaries. But I can only do my job well if we work closely together to address their deepest feelings and concerns. Just as they need me to educate and guide them regarding the nature of therapy, I need them to educate and guide me regarding what is helpful and what is not. I also need to know the impact I am having on them, especially if it results in some type of disruption of the relationship.

Most clients seem to like the idea of a collaborative relationship and feel empowered by it. I believe approaching the therapy relationship as a collaborative effort instills a sense of responsibility in clients and minimizes infantile dependency, even in the midst of significant regression, a topic I will address in the next chapter. The educative process helps prepare clients for what they will experience and reduces their anxiety when faced with the unknown. Understanding what is happening to them promotes a greater sense of control and stability.

A regressed client who suffered from an anxiety attack and depression over the weekend, for example, may come to her session on Monday saying, "I really felt terrible this past weekend and got scared. I thought about calling you, but then realized why I was feeling this way and knew there wasn't much you could provide over the phone. So rather than bother you, I just decided to wait until my session." When I was first practicing I did not explain regression to my clients when I observed significant signs of it. As a result, I would typically get frantic calls between sessions with the client panicking and asking what on earth was going on. Was she going crazy? Armed with insight about the process, clients get through difficult times on their own, decreasing their own sense of helplessness and deep dependency on the therapist.

Some clients want and need to know more than others. I generally provide basic information about setting goals, the payment of fees, the frequency of sessions, and the need for emotional honesty within the first few sessions. As I said, the client's emotional state and current needs are always foremost. In some cases, this information can be addressed in the first session. At other times, it may have to wait for several sessions. As the therapy progresses I continue to provide further education as needed. Often I am responding to the client's questions, at other times I initiate the education process in response to something occurring that I think should be addressed in a collaborative manner.

For example, a client suddenly begins to come late to her sessions. I ask for her thoughts about this. More often than not, the initial response is something like "I don't know" or "I just seem to have trouble getting away from work lately." She cannot answer immediately because the true cause of her tardiness is unconscious and needs to be explored. Rather than simply putting the onus on the client to think harder about why she is late, I approach the issue as something for us *both* to think and talk about. If my client draws a blank, I will say something like, "Let's see, you've been late for the last three sessions. So my guess is something happened, either in or outside of the session, about a month ago, making you conflicted about coming here. I wonder what it might be."

At this point I may or may not have some idea about what my client may say. Either way, I want to give the client the opportunity to identify the issue before I give any opinions about it. Often simply asking about what happened a month ago, for example, will trigger a response. The client may say, "Oh, my god, I completely forgot. I was really irritated by something you said in a session—but it just completely left my mind." Or she might remark, "I remember talking about how angry I am at my parents, and leaving the session feeling very guilty and ungrateful. I felt like I betrayed them and didn't want to again." If the client cannot come up with anything at all, and I do have one or more ideas, I will express them and ask what the client thinks. Sometimes this produces an "Aha" experience, other times little or nothing. If we get nowhere, I say there is probably something we haven't identified, but that we hope will become evident down the road.

THE CASE OF ANDREA

Andrea was a lawyer who came for therapy because she had just started a new job at a law firm and did not want to lose it. In her early 30s at the time she began therapy, she had already been fired from two law firms for her outrageous behavior toward colleagues and support staff. For the most part, she worked well with her clients and was a successful litigator. But eventually her bosses grew tired of her combative and rude behavior with other attorneys and administrative personnel.

Andrea concluded she must be doing something wrong, both because of her troubled relationships with previous colleagues and because she could not sustain a romantic relationship. She admitted

that she was very lonely and could not manage living this way the rest of her life.

She had a couple of friends, but often felt neglected and ignored by them. She was feeling desperate about her life—afraid she would end up alone and unemployed, in spite of her many talents and passion for life. She was angry at people around her, describing them as "oversensitive" and "wimps." She said no one ever confronted her directly about her behavior, they just "tattled like children" to the senior partner. "Why were people so cowardly?" she asked. She wondered why they couldn't simply approach her with their complaints and work things out.

Despite Andrea's pronounced tendency to blame others for her troubles, I couldn't help but empathize with her observation that people were generally resistant to healthy expressions of anger and opportunities for conflict resolution. Even though I understood she was overly aggressive, and no doubt frightening, to some of her coworkers, I knew the problem wasn't entirely hers. My honest sympathies with her frustrations helped create a bond between us, allowing me to emphasize Andrea's own responsibility for her situation as the therapy progressed. She reiterated, "I must be doing something wrong if I keep getting fired and no one wants to date or marry me." In the light of her emerging self-awareness, I felt there was potential for her taking control of her life and changing her behavior. Had she exclusively blamed others for her predicament, I would not have agreed to treat her.

Andrea's symptom profile was characteristic of borderline personality disorder. She had suffered from emotional neglect and abuse from her malignantly narcissistic mother. Her father left when she was only six and moved to another state. Her mother never remarried. This left no buffer between mother and daughter once Andrea reached 13, when these two strong-willed women began to clash with a vengeance. Soon Andrea was on the streets smoking marijuana and having sex with anyone who wanted her. Eventually, though, she realized these choices could lead to disaster. She decided she would not let this happen. She worked harder in high school, gained entry to and graduated from an excellent university, then did the same with law school.

When I asked her how she was able turn her life around, she credited an older man whom she had worked with at an odd after-school job. He slept with her, but was also quite nurturing and kind to her. He told her she was wasting her high intelligence and was going to ruin her life. He admonished her not to end up like him: middle-aged, earning nothing, and going nowhere. She listened. This told me two things

about her: One, she could attach and allow someone to be important to her. Two, she could listen and change if it was something she wanted to do. So I decided I could probably help her.

The first year of therapy was devoted primarily to me listening to Andrea's tales of woe, both from childhood and adulthood. I compassionately listened as she told me of her frustration, fear, anger, and loneliness. Slowly, as she could tolerate it, I began to introduce my observations of her. For example, when she came to a session upset because her paralegal complained about her verbal abuse, I asked her to give me a blow-by-blow of their interaction. Since one of our goals was to help her keep this job and not be blackballed in the legal community, I felt a keen responsibility to help her change her behavior on the job.

As is often the case with people who get too angry, there was indeed a precipitating event. The paralegal had botched an important brief Andrea needed for court that day. Furthermore, this was not the first time her work had been shoddy. But rather than taking her aside and expressing her dissatisfaction with this woman's work, Andrea berated her in front of several other employees, shouting insults at her. The paralegal then burst into tears and ran away.

Andrea saw how appalled the other employees were by her behavior. She said to me, "I don't get it. This woman loafs around the office, does shoddy work, I call her on it, and *I'm the bad guy?"* This gave me an opportunity to educate Andrea about socially acceptable behavior. I emphasized how *her* out-of-control response effectively invalidated her original legitimate complaint. I explained that no matter what someone else has done, if you verbally abuse that person, you automatically become the person who is in the wrong. Her punishments were consistently worse than other people's transgressions. Over time, I was able to help her see that whereas most people avoid conflict to the extreme, she courted it to the extreme. We discussed how neither position was viable in terms of productive communication and conflict resolution.

I also educated Andrea about her emotional problem, telling her I believed it was part genetic and part environmental, but it wasn't going away. She had to learn to manage her intense emotions and become more *assertive* and less *aggressive*. I told her I didn't think she would achieve greater impulse control until she was less frustrated in her personal life. She needed to feel less chronically lonely and rejected if her behavior was to improve significantly. The combination of a lack of any close relationships and frequent conflicts with others left her with little day-to-day emotional gratification. I explained that it was difficult for anyone to change from a position of extreme emotional deprivation.

She felt understood when I said this and readily agreed. As we predicted, when she started dating someone and this relationship lasted more than a few dates, she began to relax and have an easier time dealing with people at work.

One day she came to her session quite upset and perplexed. She said she had stopped at a video store after work the night before and had a negative encounter with the clerk. She waited in a long line, which frustrated her very much. When she finally stepped up to the counter with her video, the clerk yelled, "Don't throw that video at me. Who do you think you are? You can rent your videos somewhere else." She left the busy store humiliated and enraged. She then recalled how similar events had taken place in ATM lines and grocery stores. Once a man had threatened to hit her.

She confessed that she just didn't get it. I had her go back to what had just happened the night before at the video store. "Did you throw the video at this guy?" I asked. "No, I didn't," she replied. "Well, then, why do you think he was so convinced you did?" Andrea paused for a moment, then said, "Well, I didn't really throw it. But I might have tossed it down a bit. Maybe I shouldn't have. I was showing my frustration with waiting so long. But I definitely did not *throw it at him*." She went on to say it was not unusual for her to stimulate rage in other people, even when her own behavior was relatively controlled. She asked if I could help her understand this pattern.

I knew immediately that I could because I had experienced the same feelings with her. After a bad day at the office, Andrea would arrive for her session with anger on her face and exhibited by her body language: her posture, her facial expression, and even the way she moved screamed primitive rage. Even on a good day I felt a high level of tension and sensed that her anger could be readily ignited at any moment. So I explained how her steady state, or homeostasis, was an elevated level of defensive frustration and anger. Even when she felt "fine," to others she appeared angry and they became frightened and defensive in her presence, illustrating the unconscious "contagion" factor of emotion.

I often struggled to deal with Andrea's thinly veiled rage because I grew up with a sibling who, though not nearly as severe, had some of the same issues. I often felt victimized by her anger at the world, which provided me with insight and a level of comfort with clients like Andrea that I might not have had otherwise. But sometimes it also made me overly sensitive to her criticism and readiness to verbally attack. Some-

times I demonstrated the defensiveness I was describing to her, which she noted and we freely discussed when it occurred.

Nonetheless, Andrea's initial response to my description of her repressed rage was dismay. How could she possibly change something she wasn't even aware of? How could she change a basic aspect of her core personality? I said I doubted her battle-readiness *was completely unconscious.* Yes, she had learned to live with it, and was not typically aware of how defensive and angry she was. But was she really oblivious? When I pursued this idea with her, asking her if she didn't feel her own tension and sense the response of others, she said she had to admit that she did. But she didn't know what to do about it. I worked with her on accepting who she was, becoming more aware of her feelings, and asserting herself properly rather than waiting until she was going to explode. Many clients with borderline personality disorders are extremely unassertive, even passive, only blowing up when they are overwhelmed. Although Andrea was less passive than many clients with borderline personality disorder, she nonetheless would often wait too long to express her frustration and anger. We also talked about how essential it was for her to learn ways to soothe and relax herself.

I have left out the sometimes intense emotional exchanges between the two of us because I wanted to emphasize the educative and collaborative aspects of therapy, even with very difficult clients. I will discuss Andrea further in Chapter Seven, which is devoted to the special problems in treating those with borderline personality disorder.

THE CASE OF LAURA

I had been treating Laura for about a year and a half. She was a low-fee patient who was referred by her physician after she broke down crying during her physical exam. Her physician said her blood pressure was too high and she needed to lose weight. She was 50 years old, divorced with no children, and lived alone. She worked as an office manager and was a workaholic. Her main activities when not working were eating and watching TV. On the weekends, she visited her elderly parents who lived a few miles away. About once a week she went out socially with a sibling, coworker, or friend. She said she had been depressed since her divorce 10 years earlier, but her symptoms had worsened in the last couple of years. She had never been in therapy before but was relieved when her physician had recommended it and given her my name.

About 6 months into the treatment I offered to reduce the fee so Laura could come twice a week. She was reluctant to accept this offer, saying she felt guilty and unworthy, but eventually did. Up to this point she had established a strong attachment to me, and shown marked symptom relief. I made the offer because, to my surprise, she began regressing and instead of continuing to improve, she had begun to show signs of undue suffering and longing associated with regression.

After increasing her sessions she began to improve again. Her attachment to me continued to grow and one day she told me she loved me. Laura's treatment was intense and involved a lively back-and-forth dialogue. What follows are two important emotional engagements between us that took place during her therapy.

My relationship with Laura was a positive one, but I was not initially overjoyed to have her as a client. When she called to make the first appointment she sounded younger than her years, lively and congenial. She said she had been told I was psychoanalytic and she wanted to get to the heart of her depression.

Naturally, this was music to my ears, and I looked forward to meeting her. When I opened the waiting room door I saw this older, obese woman, who was not at all stylish in her appearance, though well kempt. Therapists can be quick to make note of the sophisticated, good-looking, wealthy people they treat. But they infrequently discuss the other side of this issue—which in this instance was my disappointment at the prospect of treating someone who, to my mind, was probably too old to change, used food to deal with her frustrations, was physically inactive with health issues, and intelligent but without any formal education. Even worse, she had no money. Her benefits were quite limited, not even covering one session per week for each calendar year, and she was up to her ears in credit card debt. Laura was not the great new client I had been expecting.

I started seeing her anyway, mostly because she cried hard during the first session and was in a great deal of pain. She said she was desperate to ease her depression but wanted to try psychotherapy without medication. I said food seemed to be her medication of choice and she agreed. I advised exercise (with her physician's approval), especially since her blood pressure was an issue. She agreed to start walking. At the end of the first session I felt pretty good about treating her, thinking she might actually improve. Even if she wasn't a candidate for analytic treatment, she was a decent, likable woman who definitely needed therapy. And she wanted to change her life.

After the first couple of months of Laura's therapy I noticed I looked forward to seeing her. She was playful and had a great sense of humor, albeit too often at her own expense. Every session she managed to display both a certain joi de vivre and an overwhelming sense of despair. She was quite verbal and easily filled the session. And she was able to listen to my interpretations, take them in, and readily gain insight into her life. She loved getting feedback and, as a pleaser, loved showing me what she could do with it. When I went to greet her in the waiting room she beamed at me as she said hello. She seemed elated to see me and have her session. Soon I realized how attached to her I was becoming.

The closer we became, the more pain she showed me. She routinely described the greatest pain in her life as not being important to anyone. She said she couldn't bear knowing she had nothing important to offer another human being. She hated believing she was incapable of enriching another person's life. I instantly knew this was not true, because she was enriching my life. And I was impressed with the nature of her concern. I haven't treated many people who spend much time worrying about their contribution to others and to the world. Laura desperately wanted to make a difference and was sure she hadn't and never would.

This brings me to my first difficult moment with her. After she had repeated this scenario with me many times, I knew she wanted some kind of response from me. But what? She told me her friends and family members were always trying to reassure and rescue her. She said she knew she must be doing something to stimulate this pity reaction, but hated being seen as helpless and needy. So I knew better than to say anything that smacked of excess sympathy or empty reassurance. She didn't want me to take away her pain, but she wanted something. What? I had fleeting rescue fantasies involving telling her that I cared deeply about her, but knew better than to enact them.

The next time we re-created the scenario where she said she could never be important to anyone or really offer them anything substantial, I said, "Then why do I look forward to seeing you?" She looked at me, registered what I said, then looked away and mumbled, "I don't know." She went on talking without discussing my comment, but I could see by her facial expression and body language that I had made an impact. The next session she told me my comment about looking forward to seeing her had stuck in her mind and meant a great deal to her. However, she quickly added it seemed unbelievable. I asked if she thought I was insincere. She said, "No, I didn't think you were making it up."

She said it was just so difficult to change how she feels and thinks about herself. She couldn't integrate what I said with her self-image: "I can't just change because of what you said, you know." I smiled and said I understood completely. I told her I knew it would take a long time for her view of herself to change. She was not finished feeling, and expressing, her self-hatred. She was glad to know I understood and said my comment had given her hope. So that's what she needed from me—to know I cared enough that there was hope of her one day being important to me.

And, of course, she needed me to affirm her unconscious knowledge of *actually being important to me.* As I stated earlier, I respected her and came to care very much about her and what happened to her. Everything I have read in the affect literature fits with my clinical experience that people know what each other are feeling, even if this knowledge is unconscious. For me, therapy has become a very different animal as I view it from the perspective of both parties always knowing what each other are feeling.

Early experience can be an obstacle to taking in current realities. As Wachtel (2007) points out, Laura's view of herself needed to change in the direction of how I, and others, actually felt about her. But this could not happen through insight alone. What was required was a series of incremental emotional experiences that gradually resulted in an observable shift in how she felt about herself.

My next example involves another intervention with this same patient. One thing I did not mention earlier was how she frequently bought gifts for her friends and family as a way of ingratiating herself. Early in the treatment we talked about her need to buy love because she didn't believe she was loveable. As Christmas approached she asked about giving me something. She said she would probably make something since she often does craft work. I said, "Do you really need to give me something rather than us talking about it instead?" She answered yes. The idea was so foreign to her she couldn't imagine not giving me a gift. So I said okay, provided the gift was inexpensive. Laura said this was not a problem—she was planning to make something for me.

At her last session before Christmas she presented me with a gift bag containing several different items. Looking at the several gift-wrapped items I said, "Did you make these?" "No," she said. "I bought them. But I didn't spend much money."

"What happened to you making something for me?"

"Well, I didn't have time, so I just decided to buy you things."

"You spent money on me even though you recently told me how broke you are and how deprived you feel?"

"Yes, I just had to. I would feel terrible if I didn't get you anything."

I looked displeased and weakly thanked her for the gifts. I didn't open them during the session because I didn't want to reinforce her gift giving. I was sorry to see she felt compelled to gift me.

At the top of the next session, which was 10 days later due to my holiday break, she began crying and told me how hurt and humiliated she was by my clear disappointment and disapproval of her gifts. She said she had felt awful since she gave them to me. Then she proceeded to ridicule herself for being such a fool and for going against what she knew I wanted. I told her I was sorry she was so hurt and I did want to discourage her from gifting me, but not at this cost. She reiterated that it was her own fault. She insisted she had set herself up to be hurt and I was not to blame. There didn't seem to be anywhere else to go with the issue at the time and she went on to discuss other issues. I knew, however, we were not finished.

One of the issues she discussed was her anger at one of her sisters who deliberately excluded her from activities with another sister when she visited from out of town. The last time her sister flew into town, she stayed with the other sister without telling anyone. When Laura discovered this, she was hurt and angry. Her sisters' behavior reinforced her belief that she was unlovable and unimportant. She thought she should confront her sister about her excluding behavior, which she has discussed with me before, but repeated how much she hated conflict.

The next week she reported a dream. In this dream she had forgotten to deposit a large check into her bank account. She found it in a drawer and panicked. She couldn't believe she had procrastinated with regard to something so important. I asked her what the dream meant.[1] She said she had obviously buried something that needed to be taken care of. I asked her what this might be. She said she had not spoken with her sister about her rejection of her. She wanted to, but was afraid.

I could tell Laura was not as open with me as usual and asked her if she had given any more thought to what had happened between us at Christmas. She said she thought about it a lot. I spontaneously said, "Have you forgiven me?" She spontaneously replied, "No." Her

[1] This dream clearly has more meaningful content than what I am addressing here. But I want to limit my discussion to what had transpired between Laura and myself at a particular point in therapy.

quick response caught her by surprise and she immediately backpedaled, saying she was ridiculously oversensitive. After all, she was in the wrong to begin with. She was positively courting rejection. What did she expect?

I said she had posed an interesting question. What *did* she expect? She replied that she had really enjoyed shopping for my gifts and getting me things she knew I would like. She said she felt great when she was shopping for these gifts—very connected to me. It made her happy. She said she just had to get me something.

I said, "You had to get me something because you love me, and you wanted me to feel and accept those feelings."

"Yes," she answered. "But all I got was your disapproval."

"So I handled this rather badly, didn't I?"

"No, you didn't. You were right about me having issues with spending and needing to buy gifts for people."

"Well, if you are convinced I was right, why haven't you forgiven me?"

She seemed pleasantly startled by this question. I said perhaps I was expecting her to change too soon. For her it was impossible to love me and not express her love through giving me something thoughtful. "After all, from your perspective, the gift was really an expression of your love for me. I should have accepted the gift graciously and given you time to change on your own."

"But you couldn't do that."

"No, I *didn't* do that. I could have. I should have just shut up and said thank you."

She laughed out loud. "Well, it's my fault too," she said.

In working with Laura I have understood the wisdom of containing strong feelings I have toward her which would be overstimulating or infantilizing, while also giving her feedback in response to her stimulating me. Laura's relational pattern was repeated as she enacted the role of helpless, needy, unlovable, and dependent person. Everyone in her life gives her advice and chastises her for her poor judgment and mismanagement of her life. Her sisters all patronize her, including the two younger ones. Laura has a restricted way of interacting with people that greatly limits what she can receive. She knows she sets people up to insult her and talk down to her, but does not know how to change.

My role was to refrain from enacting the pathos and rescue fantasies I have in response to her (conventional wisdom) while giving her some honest feedback about how I feel about her. It was difficult

to give Laura the positive feedback she needed because she constantly invited pity and reassurance. But had I said nothing about how I felt about her and experienced her, the treatment would have come to an abrupt halt.

Laura was so afraid of rejection that she never called people on their own weaknesses or bad behavior. I believe it was particularly therapeutic for me to let her know I had behaved in a way that was not only nontherapeutic, but self-serving and narcissistic on my part. I had wanted her to change to make me feel good. I was insensitive to her needs because I wanted the satisfaction of her not needing to buy me anything for Christmas. I was impatient and I did not do what was in her best interest, even though I could have easily rationalized my behavior as appropriate. As she pointed out herself, her gift giving was based on feeling as though she were "not enough" and certainly any reinforcement of this behavior on my part would not have been helpful either.

Returning to the issue of my repetitive patterns, it is evident how I gratuitously hurt and rejected Laura, making her feel bad about herself in spite of her hard work and significant progress. I realized this, even though I did not share all of this information with her. Rather, I focused on my errors and negative behaviors that caused her pain.

I think it is clear in this example how both Laura and I were training each other to behave as significant people in both our lives had done in the past. Yet we were also both struggling to create something new. I knew I had made a mistake when Laura became uncharacteristically sullen for weeks after our Christmas encounter. As someone who blames herself for everything, I knew she couldn't possibly remain distant from me unless I had done something to hurt both her and the therapeutic process.

MUTUAL INFLUENCE AND THE MYTH OF THE FRAGILE CLIENT

Schlessinger (2003) made an astute observation about our illusions regarding influencing our clients. He said:

> I am sure all analysts were warned, in the more activist moments of their training, not to disturb the transference. I have often thought that, if only I knew an easy way to disturb the transference, I would bottle it and get rich. (p. 226)

In addition to Schlessinger, Lomas (1987) and many others have made similar points regarding the inexorable nature of the transference. I would add that we can say the same for the countertransference. As we engage with our clients, each of us inevitably tries to influence the other, subtly and not-so-subtly nudging each other toward what is familiar or gratifying.

Even though psychoanalysts are not supposed to admit to deliberately telling their clients what to do, I feel free to confess I have often done so—typically when my client is about to embark on an obviously disastrous course, for example, taking up gambling as a response to money troubles, planning to cut or otherwise harm themselves in response to a stressful event, or continuing poor eating habits after being diagnosed with borderline diabetes. With one client who did not have a driver's license, I periodically brought up the issue of getting a license as one of independence. What I have discovered over the years in my outward, deliberate attempts to influence my clients is something I probably knew all along, but had to test: *My clients only allow me to influence them in the directions they wanted to move in before I intervened.*

Just as behavioral plans often simply do not work, any attempts by any therapist to get a client to do something he doesn't really want to do are likely to fail. (In spite of having made significant progress and numerous major life changes, the aforementioned client never did obtain her driver's license. She was afraid to drive and simply didn't want to.) However, clients often do throw out teasers, and even ask for direct advice, when they are seeking support for a desired change. The scant research on this topic (Curtis, 2004) shows how clients typically value advice they have asked for, while finding unsolicited advice to be unhelpful and nontherapeutic.

The counterargument to this notion of influence stems largely from anecdotal evidence describing how therapists held sway over their clients for many years, resulting in no therapeutic gain or even harm. People who were in analysis many years ago willingly tell stories about their silent, enigmatic analysts whom they were constantly trying to impress or please. Since their analysts rarely showed any emotion or enthusiasm in their efforts to remain neutral, these clients spoke of watching for the slightest change in facial expression or other body language. "Reading" their analysts became a part-time job or even an obsession. Certainly these clients must have altered some of their behaviors in the direction in which they believed their analysts would approve. Doesn't this prove clients *will* change their behaviors to please their therapists and that undue influence is certainly a concern? Yes, and no.

First, it seems evident that sphinx-like therapists create an atmosphere where their clients receive very little feedback, both verbal and nonverbal. Rather than facilitating needed affective communication, the emotionally removed and silent therapist creates a vacuum the client may work hard to fill. Rather than focusing on their own needs, clients working in this type of emotional vacuum can end up expending too much effort trying to illicit a noticeable emotional reaction from their therapists. I think therapists who are willing to show emotion on their face and give feedback when the client is soliciting it (Maroda, 1991, 1999) are significantly less likely to have clients working overtime to figure out how to please them. From my clinical experience, the more matter-of-fact I am in sessions, and the more I encourage my clients to express themselves, the more likely I am to receive criticism over time, rather than consistently receiving deference.

Of course, overly pleasing, obsequious clients exist, regardless of the therapist's behavior. My previous case example of Laura keenly illustrates both sides of the influence issue. Laura was overly concerned with pleasing me at all times, and her feelings were hurt by the slightest perceived rejection or lack of enthusiasm on my part. Yet, as the therapy progressed, she became involved with a man who was still very much emotionally involved with a married ex-lover. At first he was spending time with both Laura and his ex-lover, always claiming his only sexual relationship was with Laura. But Laura was understandably frustrated, hurt, and angry as the relationship between her male friend and his ex continued long after he said he would break it off.

She soon realized if she was ever away from him for the evening, for example, going out with friends, visiting family, or working out, he would spend the evening with this other woman. He staunchly denied any sexual involvement, saying they were just "good friends." After more than a year of being together, Laura moved in with this man. Unfortunately, the ex-lover was still making frequent appearances. Laura let me know what she wanted to work on. She said she needed to accept they were just friends and stop being so jealous and angry. At first I thought she was kidding. When I realized she wasn't, I told her I didn't think her goal was achievable. It was natural for her to resent this woman's presence in her life and to be jealous—especially since her lover told her this woman had been the love of his life, but had refused to leave her husband and marry him.

Laura became visibly upset when I said she had every right to be angry and expect more from him. What happened to the promise he had made a year ago to end the relationship? Laura hated my confron-

tation of her and let me know this was the first time she had been in love in her entire life, and at 50 she was not about to give it up. She said she could bear her lover's relationship with his ex if she had no other choice. And she believed him when he said there was no sex involved.

Any attempt on my part to encourage Laura to be more assertive, to expect more from her lover, and to accept her own feelings failed miserably. My efforts to *influence her* did not work at all—and this was with someone who had begun exercising and lost a great deal of weight at my behest, who had become more assertive with friends and family when I pointed out her nonassertiveness, and who let me know when she was unhappy with me. Laura initially loved being influenced and supported by me, simply because I was helping her to do things she had wanted to do for years.

The issue with her lover was much deeper and more significant. It was a replay of her sadomasochistic tendencies in all relationships (which can be seen in our interaction over the Christmas gifts as well), her quickly established symbiotic relationships, her extreme dependency, and her fears that any demands, even reasonable ones, would only produce abandonment.

Laura made tremendous progress in her therapy, eliminating her bouts of spontaneous crying, compulsive eating, and other depressive symptoms. She also established a richer social life. Additionally, she cut back at work and was putting in a normal work week. But further progress was impeded by her being "stuck" in a romantic relationship I perceived to be unhealthy. We had a frank discussion in which she made it clear she was not interested in making any changes that might "rock the boat" with her lover. So we decided to end her treatment on this note. She said she was grateful and pleased with the results of the therapy but couldn't help feeling she was a disappointment to me.

Thinking about my countertransference patterns, I think I could have done a better job of winding down the therapy once it was clearly stuck on this issue of the man she was dating. At first I thought we should just keep working and see what happened, but a year later she was still in the same position in relation to him, and not interested in making any changes. (For a while she had hoped this situation would be resolved by him keeping his promise to break off with the other woman. This line in the sand kept being redrawn and Laura eventually gave up on asking rather than insisting he keep his word.)

In retrospect I think most of the therapy went quite well, but I could have made the end less painful and disappointing for both of us. But I also want to note that even a fearful, approval-seeking, low self-esteem

individual like Laura only allowed me to influence her to a point. When I thought she needed to make a change in terms of being more assertive and risk taking with her lover, she resisted. This was after our repeated efforts to analyze and understand her need to be one-down and hurt in this relationship. To my mind, this was an example of how intractable certain repetitions of the past can be, and also an example of how people both change and stay the same.

Young therapists are often hopeful about completely transforming their clients' lives, whereas the reality of treatment outcomes comes closer to what happened with Laura. Perhaps if I had treated her when she was in her 20s or 30s there might have been a different outcome. But her perceived last chance at love and companionship, and her fears of being left alone in the world, were more powerful than any desires either of us harbored for her emotional freedom. All clients have areas where they prefer to remain the same, no matter how much their therapists may be convinced that change would be beneficial.

In the first case I presented in this chapter, the attorney I called Andrea, we can also observe the effects of influence. After Andrea and I had been working together for a few months, she asked if there was anything she could do to hasten the process. She knew her diagnosis, having had it yelled at her by a physician friend who was angry with her. I explained that the research on treating borderline personality disorders recommended twice weekly psychotherapy. She said she thought that was excessive, would cost too much money (even though she could easily afford it), and would be too time-consuming and inconvenient. I dropped the subject, of course, until some months later when she was having some physical symptoms suggesting regression. Her physician had said her symptoms were stress-related.

When she asked my opinion, I explained regression, and said perhaps she might be willing to try twice a week for a while. If it didn't help, then we could simply discontinue it. She accused me of wanting to take her for her money, and said she would rather suffer with her physical symptoms instead. This was the kind of comment Andrea made to others on a regular basis, and it did not particularly bother me. Needless to say, I stopped recommending any increase in sessions.

Andrea guarded against being controlled by others and hated having anyone suggest or demand she do anything. Yet when I educated her about her problems and offered to help her with strategies to increase her relaxation, find ways to self-soothe, and become more assertive, she enthusiastically participated. I ask clients what makes them feel better and work from their own existing base of self-soothing

behaviors. One person feels better when she reads, another when she exercises, and another when she talks to a close friend. Another person may find relief in a soothing bath. I emphasize that the greater the repertoire of constructive self-soothing behaviors, the better. (The list obviously excludes use of drugs, excessive use of alcohol, and overeating.) I also let my clients know that they should not be discouraged when a single method of self-soothing fails, even when it has worked well in the past. I say that all activities can lose their stimulus value over time, and it is good to mix up whatever methods you decide to use. If one thing doesn't work, move on to another until you find one that works in that moment.

Andrea worked hard and improved tremendously. She gained better control of her behavior when she was upset, became more assertive, and learned to self-soothe. She made partner at her law firm, went through several relationships, then fell in love and got married. When we terminated she said she had achieved everything she came to therapy for, and we said a mutually appreciative and sad good-bye.

Andrea was more than willing to be influenced on certain issues, and not on others. She was afraid of intimacy and the thought of coming twice a week was terrifying rather than comforting. But she prided herself on being practical and realistic about solving problems. Even though she hated realizing she had significant mental health issues, she gladly dug in and addressed them as well as she could. She worked collaboratively with me, as she would with another attorney to prepare a case. As long as I didn't get too close emotionally, her attitude was "Whatever it takes. I want my life to change."

Am I suggesting that clients will either leave or resist any undue therapist influence? If so, then we need not worry about damaging them. Certainly, I am not saying it is impossible to damage a client. Damage can, and is, done by therapists on a regular basis. Much of this damage is the result of unethical behavior or incompetence. Also, certain clients with a tenuous hold on reality will be more susceptible to destructive influence than the typical outpatient client I describe in this book. Clients with a history of masochism or obsessional attachments are also more likely to remain in therapy relationships that are not helpful or even harmful.

From my experience the clients who are the most damaged in the course of therapy are the ones who become the "love objects" of their long-term therapists. Therapists who hang on to clients for years so those clients can meet their needs to be admired, loved, even understood, do them a great disservice. I have had many clients come to me for therapy who have tried several times with other therapists and were

disappointed with results. Most of them left after a few sessions or a few months. None expressed more than irritation or disappointment. I find the clients who strongly felt they had been exploited or damaged were those who stayed for years with narcissistic therapists, being used to shore up their fragile self-esteem. We associate sexual contact of some kind with this sort of outcome, but the error or transgression is not necessarily overtly sexual (Celenza, 2007). A therapist who wishes to be ethical but is struggling with personal issues may take a great deal from a beloved client without crossing the sexual transgression line.

What I am arguing against is not the idea that we should take our clients' vulnerability or our fiduciary responsibilities toward them for granted. Rather, I am arguing against the misguided notion that *most* of the people we treat are incredibly fragile and cannot bear the truth—either about themselves or us. Granted, this is not something we are going to confront them with prior to establishing a good working relationship. But I have witnessed too many therapy relationships where the client is frustrated, asking for feedback, wanting to go further, and it is the reluctant, conflict-avoidant, fearful therapist who holds him back. Walking on eggshells and being overprotective, even patronizing, toward our clients is not a helpful stance. It does not convey or inspire confidence, and it does not produce change.

SUMMARY

Both participants in the therapeutic process bring a core identity and established ways of being to the therapeutic relationship. Although the primary emphasis is on the client, real progress often requires the therapist to be equally aware of her own need to repeat the past. Inevitably, both therapist and client stimulate each other emotionally and bring up old feelings of fear, guilt, sadness, shame, anger, and desire. Understanding that no feeling state is inherently destructive can help both therapist and client to accept who they are. Acknowledging the inexorable pursuit of self-interest and mutual influence can aid the therapist in calmly accepting her own role in the therapeutic process. Clients who have difficulty navigating the world typically have not had sufficient recognition of their reality and their observations of others. Much of what the therapist has to offer is not being the perfect *other,* but rather the imperfect person who is willing to admit to her mistakes and self-interest. Doing so facilitates new patterns of feeling and relating, promoting growth and permanent change.

3

Redefining Regression

Facilitating Therapeutic Vulnerability

> When the therapist is overimpressed with or frightened of the patient's emotions and blocks them, or hospitalizes the patient unnecessarily, the patient not only fails to become able to bear his emotions but compounds his dread of them.
>
> —Henry Krystal (1988, p. 29)

Once the therapist and client establish a rapport and are communicating well with each other, the relationship begins a natural evolution. Factors affecting this evolution include the emotional availability of client and therapist, the expectations for the length of the therapy, and the extent to which the client has deep concerns that need to be addressed. While some clients will remain entrenched at more surface levels of experience, others will move into deep painful feelings, a process that has traditionally been referred to as "regression." Regression is necessary for any deep change simply because it is the process whereby defenses are weakened and the client is able, in conjunction with the therapist, to create new experience.

The therapist understandably feels both excitement and some fear in the face of a client moving into deep pain, especially if the client presented with a more well-defined situational problem—for example, losing a job or ending a relationship. Both therapist and client sense a change in the atmosphere. Instead of pressured talking, there may be longer silences, references to things the client has never told anyone else before, and a sense that something important is happening.

For example, Robert, a businessman in his mid-40s, came to therapy to deal with the public failure of his family business. He felt humiliated by the descriptions in the news media, particularly because his father had started the business. Although Robert had expanded the business and made it much more successful, sudden market changes beyond his control brought about its failure. Robert said he simply wanted some short-term therapy to deal with his depression and help him feel more positive about the new business venture he was undertaking. He had acquired new partners who believed in him and he wanted to rebuild his life. He felt he had not adequately dealt with his anger and public humiliation because he avoided discussing it with anyone, even his wife. He felt she had been through more than enough with the bankruptcy and didn't need to be burdened by his emotional distress.

Robert spent the first two sessions explaining the circumstances of the business failure to me and the impact it had on him. He was aware of his feelings of frustration, anger, and shame. His emotions were evident and he talked in a pressured, nonstop manner. At the third session he mentioned his father, who had died 10 years earlier. He emphasized the high regard people had for his father. I saw a look of intense pain on Robert's face as he spoke of his father and knew at that point I had a decision to make. Was I going to pursue this deep pain related to his father, or was I going to stay more at the surface, simply noting that Robert was expressing a lifelong admiration for him?

Not having any constraints on the number of sessions, which is definitely a factor in how deep a therapist can attempt to go with a client, I made the decision to address Robert's deep pain. I said I noticed how sad he looked and thought he missed his father very much. Perhaps he felt he had let him down by losing the business. Robert broke down crying, covering his face with shame. The remainder of the session was devoted to discussing Robert's feelings about his father and he left both shaken and relieved by this unexpected wave of emotion.

Bridges (2005) notes the frequency with which experiencing intense feelings can be accompanied by a deep, often inexplicable, sense of longing. She says that as deeper feelings emerge, a state of emotional disequilibrium often follows and, depending on its intensity, may make the client feel anxious or even panicky. Not having had this experience before, a client may fear that he is going crazy or that the therapy is making him worse rather than better. (Even if the client does not feel this way, family and friends may and will want to know why he seems worse to them.)

This lowering of defenses and movement into deep, often previ-

ously unexplored, sadness and longing has traditionally been referred to as "regression." Unfortunately, the term is meaningful mostly to experienced clinicians who know it when they see it and have learned how to handle it through trial and error. Regression has not been clearly defined in the literature, the expectation being that everyone knows what it means. There has been much debate in the analytic world about whether regression is spontaneous or induced, therapeutic or nontherapeutic, mutual or unilateral, universal or common primarily to clients who have been traumatized. (See Aron & Bushra, 1998, for an excellent review and discussion of the literature.) One of the purposes of this chapter is to focus on a meaningful clinical understanding of the concept.

Regression has become an outmoded term, particularly outside of psychoanalysis, and yet no new term has been created to define the process whereby the client, and to some degree the therapist, let go of their defenses in the interest of communicating at a more basic affective level. (See Aron & Bushra, 1998; Maroda, 1991, 1998a; and Coen, 2000, for discussions of mutual regression.) The experiences that typically promote regression are falling in love, long-term therapy, having a baby (women will tell you this is a form of falling in love), and being ill. In all these situations the individual's defenses are let down, not through conscious choice, but as result of a person or an event piercing her defensive armor. When this happens she is flooded with unexpected and hard-to-control emotions. Sometimes these emotions seem completely new. When someone falls in love for the first time she is likely to say she has never experienced anything like this before and has discovered an aspect of herself that she didn't know existed. A new mother often says similar things—that she had no idea how childbirth would irrevocably change her. Those who suffer a significant injury or illness may describe a less pleasant but equally powerful sense of vulnerability and openness to new emotional experience.

Regression as defined by early psychotherapists was considered a defensive move by the client, a retreat to an earlier stage of development. Slowly it came to be seen as not primarily defensive, but rather as an "opening up"—or breaking down of walls that prevented the surfacing of deep, primitive feelings. I think that it was initially seen as a negative phenomenon in part because it can be so difficult to manage clinically. But gradually clinicians came to understand that being emotionally lost often preceded significant change.

So why did the term "regression" fall out of favor and use? I

think it happened primarily because of its association with hypnosis and the recalling of "past lives" while in a hypnotic state. Many people are understandably skeptical of this process and take a dim view of it. Therapists who implement intensive 24/7 interventions, encouraging their clients to return to infantile states, including being fed from a baby bottle, have also given regression a bad name. The use of the term "regression" in this book refers to the aforementioned dropping of defenses in response to empathy and attaching to the therapist. Regression defined in this way is critical for a successful in-depth treatment.

Yet I am aware that regression has its dark side and can spiral out of control if the therapist is not skillful in facilitating it. Some regression, or letting down of defenses, is required for deep change. But many clients who have suffered early trauma or have a psychotic core do more than become vulnerable when their defenses are let down. They can easily decompensate, even temporarily. The sight of a decompensating client is often frightening to a beginning therapist or any therapist who has not been trained to manage it. Clients with a history of anxious attachment, or those with a deeply buried psychotic core, may decompensate quickly to levels that are no longer therapeutic.

For example, I was in the audience during a case presentation at a conference where a female client in her 50s with borderline personality disorder was presented. She quickly formed a dependent attachment to her therapist, regressed nontherapeutically (including lying on the floor in a fetal position in the therapist's office), and requested more and more sessions. She was independently wealthy and her requests for more sessions were granted. This was followed by requests for more and more phone calls, including calls while the therapist was away on vacation. The therapist who presented this case seemed well intentioned and honestly believed that she was helping this client. But, to my mind, she was indulging her client's infantile dependency needs and rescue fantasies. At some point, a therapist who has created this type of excessive dependence and reinforced infantile behavior will have to say "No."

Therapists who have not been educated about regressive experiences in therapy, and/or who have not experienced something similar in their own therapy, may be frightened and taken aback by the sight of their clients' emotional unraveling. Even those who can sense that something positive is happening may still be at a loss for how to explain it, and how to optimally manage it. Add to the mix the situation that the therapist is likely to experience some degree of regression

in response to her client, and both people may begin to sense a loss of control. Robert Langs (1974) says:

> All too often, the therapist is frightened by the sudden appearance of symptoms such as psychosomatic reactions, phobias, or anxiety attacks, and other regressive phenomena—sudden dissociated states, acute failures in reality testing, paranoid reactions, psychotic-like decompensations—and is prone to reassure himself by resorting to ill-defined "supportive" interventions. Such empty verbalizations or offers of medication made without insight or understanding, only increase the patient's anxiety, since he is usually unconsciously, and even consciously, aware that the therapist is frightened and confused, and in a sense, regressing, too. (p. 387)

Medication may indeed be necessary for some regressed clients, particularly those who suffered childhood trauma and may have difficulty negotiating reality during periods of deep regression. Langs is not suggesting we deny medication to clients in dire emotional straits. Rather, he is pointing out that therapists who do not know how to manage their clients' or their own regression may prematurely, and in an obvious sense of panic, rush to medicate and/or hospitalize a client who may merely need to have the therapist explain what is happening and help her to manage her emotions.

SIGNS AND SYMPTOMS OF REGRESSION

The first step in learning how to facilitate a therapeutic level of regression is knowing what therapist behaviors are likely to encourage this dropping of defenses, how to identify when the client is regressing, and how to know when it is therapeutic and when it is not. Some clients regress rather quickly (2–3 months). Those who are going to regress usually do so within the first 6–12 months. The symptoms of regression may not appear until later, but this is likely due to the client's reluctance to acknowledge the accompanying feelings, either to herself or her therapist. Fears of embarrassment or of being hurt may keep these feelings suppressed.

One client I treated said she recalled leaving the first session with the sense that she would die if she never saw me again. Needless to say, she became regressed and dependent early in the therapy and was difficult to treat. However, many clients do not regress to any significant

degree, especially if they only come once a week or if they are middle-aged or beyond.

One of the attacks on psychoanalysis has been that regression is an artifact of being seen multiple times per week and has no real therapeutic value, chiefly because it can be difficult to manage and often ends badly. Yet anyone who has been doing work that is aimed at symptom relief and defined as short term is sure to report that he has had many clients regress at only once a week, and without any encouragement on the therapist's part to do so. My point is this: Whether or not a therapist is interested in long-term work or anything psychodynamic, and even if he never sees anyone more than once a week, he *will* be faced with a regressed client from time to time. So the more beginning therapists know about this phenomenon, the better. Here are some of the client behaviors that may indicate regression.

1. The client may state that she feels confused about what she is experiencing—that it is something new and a bit scary.
2. The client shows signs of "unraveling"—crying deeply and easily, often as the session begins. She may report crying uncontrollably at various times.
3. The client may begin focusing on the transference, making comments about the therapist as a person, including expressing affection, sexual attraction, and/or admiration. (Fears of being rejected or a sense of inferiority to the therapist may appear as well.)
4. The client may fall ill, but not seriously. A series of colds or flu are not uncommon and are often precipitated by the therapist's absence.
5. The client may wake up with intense dreams and nightmares, may wake up crying from a dream, or may awaken with intense anxiety or even an anxiety attack.
6. The client may ask for more sessions or may start leaving frequent voice mails or e-mails for the therapist. She may ask for a callback or may simply leave a message. This is in the interest of making a connection. Clients who have more problems with object constancy will need more contact than those who do not.
7. The client may start to complain that the treatment is too painful, may fear that she is not getting better, and may criticize the therapist. This can alternate with idealizing and loving the therapist.

8. The client may withdraw from contact with others, preferring to focus on her own process and the treatment relationship. She may refuse normal contact with family and friends, which can lead these people to think that the treatment is making her worse rather than better.
9. The client may seem excited at the sight of the therapist, throwing longing looks as she sees the therapist in the waiting area.

This list is not exhaustive, of course, and one of the enjoyable aspects of doing therapy is that any given client may surprise you with something you have not experienced before. But this list is a reasonable starting point for identifying regression. Once the client has regressed, the issue becomes neither shutting this process down due to fears of being out of control, nor encouraging it to the point where the client has difficulty functioning both within and outside the therapy.

UNDERSTANDING REGRESSION

How do we know what level of regression is therapeutic and what is not? This is a difficult judgment call, given that regression is not a static state but one that fluctuates not only from session to session, but sometimes from moment to moment. Perhaps this fluid and elusive quality of regression has led to the lack of attempts to operationalize it. Michael Balint (1968) dared to describe regression in clinical detail and attempt to delineate types of regression that were therapeutic versus nontherapeutic. He coined the terms *benign* and *malignant regression* for these purposes. Although this "disease" categorization is outdated and probably objectionable to many people, some understanding of therapeutic versus nontherapeutic regression is invaluable. We also need to keep in mind that clients are not so easily categorized and often fluctuate between these two types of regression, based both on their own vulnerability in the moment and also the therapist's ability to respond in a helpful manner.

THERAPEUTIC REGRESSION

Therapeutic regression occurs when the client's defenses break down and she opens up to the therapist. This process is attachment-based

but unconscious. According to Balint, this form of positive, therapy-enhancing regression is characterized by the following:

1. Client's ability to establish a trusting relationship with the therapist.
2. Client's ability to resolve conflicts and achieve insight and integration.
3. Client's overall capacity to express, process, and integrate deep and primitive emotions.
4. Client demonstrates moderately high intensity of demands, expectations, or needs.
5. Client does not exhibit severe hysteria or acting out.

Clients who are experiencing a therapeutic regression may occasionally ask for a phone call, seek some reassurance that this is a normal part of the process, or spontaneously hug the therapist at the end of the session. These small gratifications, particularly when asked for in a nondemanding way, do not usually present a problem. The key to providing a therapeutic amount of gratification is to avoid giving anything the client has not asked for and to not give anything you are uncomfortable giving. It is wise to keep in mind that something you may be comfortable with at one point, you may not be comfortable with at another.

For example, Dr. W. attended one of my presentations and heard me mention how humiliating it can be for clients when their spontaneous hugs are met with physical distancing or tensing. During the question-and-answer period, she brought up a client of hers who had hugged her a couple of times at the end of intensely emotional sessions, over a period of a year. Dr. W. said the hugs were brief and did not present a problem to her. However, lately her client had begun hugging her at the end of almost *every session,* which made Dr. W. understandably confused and uncomfortable. Yet she did not want to humiliate her client by asking her to stop hugging her.

She asked what I thought about this. I asked Dr. W. how long ago the hugging started. She thought for a minute and said, "About 3 months ago." I asked her, "What changed in therapy around that time?" She thought for a moment, then realized she had a family crisis that had left her less emotionally available to her clients. I suggested that she broach the topic gently with her client, acknowledging that she has been a bit preoccupied lately and couldn't help but notice that this client had begun hugging her at this time. Could she speak about

her feelings about therapy and what might be going on that she felt the need for a hug at the end of each session?

I was speaking in another part of the country, so I do not know how this situation was resolved. But from my own experience, this type of consultation with the client typically leads to a mutual understanding and resolution of whatever was occurring. I told Dr. W. it was important for her to let her client know that the hugs indicated to Dr. W. that she was not getting what she needed in the sessions. That way the client is freed up to discuss the issue of hugging without undue embarrassment. The focus is aptly put on understanding what is happening in the relationship, rather than on someone doing something wrong.

THE CASE OF SALLY

Sally, a woman in her 30s, reluctantly called me for an appointment at the urging of a sibling, who had been in analysis for years and found it helpful. Sally had experienced a difficult childhood, with daily verbal and physical abuse from her mother. Very much a survivor, and rightfully proud of it, she had married young to a hardworking, successful, rather reserved man, who valued stability. He gave her what she had missed in her formative years. They proceeded to have two children and their financial stability allowed her to stay at home to raise them.

Sally loved her children and doted on them, sometimes to a fault. Wanting to provide for them what her mother did not give her, she overindulged them and then was hurt and angry when they were demanding and disrespectful. Having matured and found stability in her marriage and family life, she came to therapy because the initial gratifications of marriage and young children were increasingly giving way to depression and anger. With her children entering adolescence and becoming more independent, she felt alone and unhappy.

Her husband was tiring of her frequent angry outbursts and complained of a lack of emotional and physical intimacy. Sally said that she often thought about fleeing her marriage but knew her husband was a good man who loved her and that leaving him would probably be hugely self-destructive. She felt herself on the precipice. Could I help?

After a few sessions it became evident that Sally was suffering from years of overcompensating for her early neglect and abuse. Some 15 years of working overtime to be the perfect wife and mother had taken its toll. With her children becoming more independent, she could no longer lose herself emotionally with them and her husband's once

desirable steady, compulsive personality began to grate on her rather than gratify her. When the children's grades were not good or they behaved badly, he blamed her and told her to fix things. She was bored, depressed, angry, and guilty. It soon became clear that her adaptation to marriage and family life was no longer working. The emptiness, feelings of inadequacy, and loneliness of her childhood were surfacing. She could no longer hold these failings at bay by losing herself in her duties and her children's lives.

When she asked me how therapy could help, I told her that her steadily increasing depression and anger were a defense against her sadness and loneliness. We would talk and get to know each other. Then, if things went well, she would begin to relax her defenses and these feelings would come to the surface and she could grieve what she had missed and gain more awareness and better control over her emotions. She said she wasn't sure she could do this, but would give it a try.

The first few months were spent doing problem solving about the children. I helped Sally understand her adolescent daughter's need for independence. I explained that her daughter was not grateful when Sally did too much for her because she was inhibiting her daughter's natural need for autonomy and mastery over her own life. With some difficulty, she began to lessen her overmonitoring and overprotection of her daughter. I enjoyed doing therapy with Sally, even though I hoped that we could eventually move past this stage into something deeper. I passed the tests she needed me to by being nonjudgmental and educating her about the impact of her behavior on her children and her husband. She was open to seeing and correcting her parenting mistakes and worked hard between sessions, gratifying me with her reports of improvements on the home front. She was insightful and quick to grasp the underlying motivations for her behavior rather than simply changing on the basis of my advice. I gave this advice only in response to Sally's requests, and only after asking her to think these situations through herself first. If I saw she was missing something important in any scenario she described, then I pointed it out to her.

For example, she complained bitterly that her daughter did not get up on time for school. Sally said she was sick and tired of going upstairs to her daughter's room as many as six times in a morning to make sure she was up. I gently let her know that this strategy would never be successful. She was reinforcing her for *not getting up.* I said, "Why not give her an alarm clock and have her be responsible for getting herself up and ready for school?" Sally was amazed when this simple solution

worked. As a result she started rethinking some of her other enabling behaviors.

After about 6 months I noticed that Sally arrived earlier for her sessions, enjoying some presession time in the waiting room. When I opened the door to get her, she smiled at me and I sensed her relief at beginning her session and pleasure in seeing me. Something bigger was happening. Slowly, with the "fires" at home under control, she began to talk about her childhood. Her lack of self-pity made it easy for me to like her and feel her pain, but it also fueled her "let's get on with it" attitude that thwarted my attempts to get her to linger in painful feelings. She believed in pulling herself up by her bootstraps, not dwelling on the past. I admired her tenacity, particularly her ability to still love her mother, whom she saw but kept at arm's length. She said she knew her mother was mentally ill and was not capable of more. She could be angry, but how could she hate someone who was this damaged? I sensed she needed to feel more sympathy for herself and less for her mother, but I also knew these attitudes had in some real way saved her.

As I was wondering what might facilitate her getting to deeper feelings, fate stepped in. Toward the end of the first year of treatment a close friend of hers was diagnosed with terminal cancer. As sad as this was for her, it was the precipitant for her letting go. The sadness she could not feel for herself because it seemed too scary and too self-pitying, she could feel at the prospect of losing her friend.

When she first told me the news, she simply said, "This really sucks." But I saw the deep sadness on her face and mentioned it to her. In fact, whenever Sally used her irreverent humor, even if it was funny and I laughed in the moment, I always worked at using emotion language, noting whatever expression was on her face.

Confronted with her friend's illness, Sally began to grieve, crying both in and outside her sessions for the first time. She also became pensive, withdrawn, and stopped her perpetual motion of activity. In fact, she did the minimum required of her as a wife and parent. She said it was scary, but actually felt good in an odd way. What was happening to her? Was this okay or would she continue retreating until she didn't want to see anyone or leave her bed? Was it really okay to just loll around the house once the kids were off to school, or take a nap? Why was she not interested in seeing anyone? Was she deteriorating?

I asked her what her intuition told her, and she said she mostly thought this was strange but good, and would not last forever. I told her she was right and explained regression and its therapeutic benefit.

Sally expressed relief, both that she was actually making progress, and that I understood and accepted what she was experiencing. Her sessions had always passed quickly, given that she is quite intelligent, verbal, insightful, and has a good sense of humor. But soon her sessions seemed to fly by, something she verbalized, but that I experienced as well. Sally without all of her armor—without her humor, without her crises, without her strategizing—was a pleasure to be with. Both of us experienced a sense of peace in her quiet discourse and sadness. Unlike some treatments, there were not really any dramatic moments or revelations. She said she didn't seem to be talking about anything much, but she always felt better. Was she being productive? I said I understood what she meant. I kidded with her and said that her sessions reminded me of *Seinfeld* in that on the surface they were about nothing but, in reality, they were about everything. She laughed and agreed.

Sally's regression with me easily fits into Balint's definition of benign, or therapeutic, regression. To recapitulate, she was trusting (although not immediately), made few demands, was willing to experience deep pain and saw the value in it, eventually was able to express her pain, used that pain for greater insight and integration, and actually decreased her acting out because she was more in touch with her feelings.

Sally was able to manage her regression due to several factors. First, she lacked a sense of healthy entitlement. Her expectations from other people were generally too low rather than too high. Rather than making demands, she was accustomed to suffering and took it well. Second, she had the structure and responsibility of children and a household, which required her to maintain a certain level of ego functioning and reality checks. (Be careful about helping someone to regress who is already socially isolated, unemployed, or otherwise without any meaningful expectations for participation in daily life.) Third, I maintained the boundaries, which helped make her therapeutic regression possible.

For example, at one point a friend of hers asked if she could see me for therapy and Sally mentioned this to me. I said I didn't see friends, family members, or any close associates of my clients, but I would be happy to refer her elsewhere. Sally was much relieved and said that made a lot of sense. Also, there were times when her sessions flew by and I felt an emotional pull to extend them if I had the next hour open. But I learned early in my career that no matter how much I might want to do this, it never worked well. While extending sessions can easily be rationalized as humane and generous, especially in light of the immedi-

ate gratification and sense of specialness the client experiences, generally it is a bad idea. When I extended sessions as a young therapist I soon discovered that my clients were justifiably confused, hurt, and angry when this additional time was not consistently available. Extending sessions can also be overstimulating to the client who is in the throes of love and dependency. If the therapist is willing to break the frame by extending the session, what else might she be willing to do?

Also, extending sessions can lead the client to unconsciously break down at the end of sessions in an attempt to "earn" this extra time. I think it is the responsibility of the therapist to help the regressed client compose herself sufficiently at the end of a difficult session, even if this requires notifying her 5 minutes prior to the end. In fact, many of my clients have asked me to do this because it is so difficult for them to keep track of time when they are lost in emotion. This seems like a reasonable request to me, and has worked well to facilitate the end of sessions and avoid running over by more than a couple of minutes.[1]

Since Sally was so reserved and undemanding, she did not make any phone calls to me outside of the sessions, but most regressed clients do. I permit this but do not encourage it. I limit phone calls to about 10 minutes, and let my clients know that this is my policy because having an impromptu session on the phone is not the same as in-person sessions and has the potential for going awry. If the client is in great distress, I encourage her to come in for an extra session and will go out of my way to make this happen when there is a genuine need. Interestingly, this offer often serves as a litmus test: the client on the phone who was sobbing one minute can quickly change to saying, "Oh, no, I don't have time to come in tomorrow. I am too busy at work." I view this as human nature rather than manipulation. We all want some gratification when we are in pain. But if the client is really in ongoing distress, she can usually make time to come in.

NONTHERAPEUTIC REGRESSION

Nontherapeutic regression occurs mostly in clients who have insecure attachment patterns and cannot control their affective states. Although

[1] I do not see my clients back to back so that an extra minute or two can be taken, if necessary, for the client to finish a thought or gather her feelings. I work to begin and end on time, and only take that extra minute or two if it is needed. My session length is 50 minutes, leaving 10 for writing notes and returning phone calls.

this type of regression may occur simply because of the unstable ego of the client, it is often exacerbated by therapist difficulties in limit setting and/or therapist feelings of fear and confusion in response to the client's intense emotional experience. Excessive reassurance and placating of the client also perpetuates malignant regression. This form of dysfunctional therapist–client attachment is characterized by:

1. A relationship that breaks down repeatedly and a client who clings excessively, one who is unable to trust the therapist and stay connected between sessions.
2. A client who does not use tapped emotions successfully for new discovery. Rather, he or she becomes agitated and may exhibit a phobic reaction to intense pain.
3. A client who has difficulty resolving conflicts with the therapist and often seeks gratification more often than insight. He or she may increase demands for soothing from the therapist.
4. The presence of emotional storms, an inability to regulate affect even with the therapist's assistance.
5. Threats of self-harm if the therapist does not meet the client's expectations to be pacified or rescued. A client may carry out these threats when anxious attachment becomes unbearable.

Many therapists inadvertently promote this nontherapeutic form of regression through a series of placating gestures toward the client who is in pain. The client may make demands for extra sessions, frequent or long phone calls, personal information about the therapist, fee reductions, or physical contact. It is not uncommon for therapists to indulge these requests if they start small, like asking for a phone call. But too often *escalating* demands are indulged because the therapist does not know what else to do or because she fears that the client will follow through on threats to harm herself if she does not get something more from the therapist.

In the throes of the client's overwhelming sense of hopelessness, often accompanied by bitter complaints that the therapist is not doing enough, the therapist may be tempted to indulge a childhood-based demand for some type of rescue or love cure. Gabbard (1996b) and Celenza (2007) have reported this scenario as the most common one preceding sexual boundary violations. Balint (1968) talks about how when treating the regressed patient one may "be seduced by the unending suffering of the regressed patient into accepting responsibility for creating conditions in which, at long last, no more unnecessary suffer-

ing will be inflicted on him. Although this appears to be a highly commendable rationale, experience shows that it rarely works" (p. 111).

A classic case history involving malignant regression can be seen in Sandor Ferenczi's (1932/1988) report of his work with the American psychotherapist Elizabeth Severn, whom he codenamed "RN." He conducted his now famous experiments that consisted of providing many additional sessions and generally capitulating to her demands. These demands included holding the sessions at her home when she felt too "weak" to leave and trading places on the couch every other session for what Ferenzci called "mutual analysis." (See Ragen & Aron, 1993, and Fortune, 1993, for further discussion.) As these indulgences continued, RN got worse, not better. She continued to decompensate, increasing her already substantial demands on Ferenczi. Convinced that his initial emotional availability and keen empathy had been therapeutic, helping her to feel more deeply than she ever had in the past, he was at a loss to explain why she was deteriorating as the therapy proceeded.

I discuss this case in detail elsewhere (Maroda, 1998a), but probably the most important fact to surface from Ferenczi's experiments with RN was his acknowledgment that he had pacified her during a period of time when he was becoming increasingly angry at her.

AFTER-HOURS PHONE CALLS

Early in my career I responded to clients' phone calls by being overly empathic, which almost always led them into deeper pain. Since being highly empathic worked well in sessions, I responded in the same manner when speaking to a client on the phone. It never occurred to me that I should act differently when responding to a distressed client asking for phone contact. Often these phone calls were long (up to an hour) and were naturally gratifying (including being free) to the client. So it took me some time to realize that this was not a good way to practice. Only after repeated incidents where my clients were confused, hurt, and angry when I was *not* available, or could talk for only a few minutes because of other commitments, did I realize that my approach was simply not working over the long term. Having had no instruction, either formally or in supervision, regarding how to handle a phone call, I had to learn the hard way.

Once I realized that phone calls needed to be kept to a minimum and not encouraged, my therapies with regressed clients went much more smoothly. Ten minutes or so, aimed at helping them manage their

distressing emotions, was something I could consistently give, but also something that was clearly not what they got from their sessions. Paling in comparison, phone calls became less gratifying, and less frequent, which was better for both my clients and me (not to mention my family and friends).

When I decided to change my behavior with regard to phone calls, I simply told the clients who made calls to me that I was making the change, and why. Some of them were not very happy, but chiefly because they had to give up something that was gratifying. Virtually all of them acknowledged that the phone calls were too unpredictable to be consistently beneficial and they all accepted this change. I also took full responsibility for any pain that my previous policy had caused them. For some, I had to assure them that they had done nothing wrong and that this change was not a punishment but rather an effort on my part to provide more consistent and efficacious treatment.

When new clients ask about calling me when they are in distress, I tell them from the beginning that I keep phone calls to a minimum and also tell them the hours I check in on both weekdays and weekends. After that, if there is an emergency, they must use a 24-hour hotline or go to the emergency room. Having convinced myself as a young therapist that my clients really needed me, I was amazed to discover how even the most disturbed, regressed clients made do with minimal phone contact. (Now that e-mail has become an issue as well, I tell clients they may e-mail me, but that I do not respond to e-mails, only receive them. For anything more urgent, they should call. I read all e-mails sent to me, print them out, respond to them in the next session, and save them in the chart.) I have come to believe that our clients need us in proportion to our need for them. So keeping these strict limits may be impossible for a new therapist who is still working out his or her own issues (including needing to be needed). But I mention it as something to work toward, and to alert new therapists to the pitfalls of providing long, gratifying phone calls on their personal time. Not only is it impossible to consistently provide this kind of attention, but for many clients this is a deeply personal, even romantic experience. And if there is no charge, it has a similar effect of not charging for an in-person session: Is the therapist guilty about something? Is the therapist too invested personally in the relationship? Does the therapist feel inadequate? Is the client special?

All of these factors are involved in phone contact, whether or not the client is regressed. But most clients who call with any frequency are regressed, as defined earlier, and are much more likely to read more

into this out-of-session contact. Add to the mix a tired therapist and talking on the phone in the evening is more likely to blur the boundaries. Maintaining boundaries on the phone is as essential as doing so during the actual therapy session, and may initially require extra self-awareness and vigilance on the therapist's part.

A CASE OF NONTHERAPEUTIC REGRESSION

Describing a case of nontherapeutic regression is more difficult than illustrating the aforementioned case of therapeutic regression (Sally). This is true for several reasons, the most important being that an honest therapist will have to admit to having played a large role in creating and/or maintaining a nontherapeutic environment. The first step for any therapist who finds herself in this situation is to ask, "What am I doing now, or what did I do in the past, to encourage this type of regression?" Although we have all had the experience of having regressed clients move in and out of periods when they were regressed nontherapeutically, it is only those who get locked into that position whose treatments ultimately end badly. Talking about this kind of result is difficult for any therapist, including me.

The client I want to present here is one I wrote about at length previously (1999). To this day I do not know whether she was treatable. But I do know that her therapy with me ended in a way that was unsatisfactory for both of us. I called her Susan in my previous book, so I will continue with that pseudonym here. In brief, Susan was an extremely difficult client—perhaps the most challenging I have ever treated. She had had sex with her previous therapist, and then ended the relationship with an expression of contempt for the therapist. Rather than presenting herself as a victim, she did the opposite. From her perspective, her therapist was unworthy of her and when she realized it, she ended the relationship. Susan had a history of childhood emotional and physical abuse, and was alexithymic (unable to express any strong feeling other than anger and without much insight). She presented as put-together and in control—so much so that her most recent therapist dismissed her after only a few sessions, telling her she didn't need therapy.

The precipitant for her coming to see me was a debilitating depression that left her unable to work or sustain a relationship. She had a few friends, but had no partner and no job when she came to see me. I accepted the referral because it came from a therapist friend of mine and because I had just ended with two people and had open hours.

From the beginning I had mixed feelings about treating Susan, and I should have paid more attention to them. The facts that Susan not only had a history of trauma, but was also power-oriented, without insight, and unable to consciously experience deep feelings should have made me more reluctant to accept her into treatment. And it most certainly should have been an indication that I not see her more than twice a week.

Initially I did see her twice a week, but she told me she was living off an inheritance and wanted to make the most of the time she was taking off from working. She had been reading up on psychoanalysis and wanted to do the real thing. These are words I don't hear from many clients and I was excited by the possibility of analyzing Susan. The old rule of thumb in analysis is that the therapist should follow what the client says about how many sessions she wants and can handle productively. In the past, this guideline had always worked for me (which I suppose is an apt illustration that any guidelines, including the ones I provide here, will have exceptions). I was even excited about having a client come four times a week, given that most of my clients came two or three times.

Shortly into Susan's analysis things began to go awry. She wanted to use the couch, but quickly showed signs of decompensating. When her sessions were over, she did not want to leave and routinely departed in a rage, slamming the door behind her. When I worked to get her to relax and experience her pain, she sometimes lost touch with reality, in that she became convinced that I was not just facilitating her experience of pain—I was causing it. For Susan, it didn't matter that all I was doing was asking her about her childhood experiences. To her, if she felt pain while in someone else's presence, then that person was *causing* her pain. We talked about this during calmer moments, with me telling her that if we couldn't find a way out of this logjam, this treatment would not work. She assured me that intellectually she understood that I was not harming her, but that she lost track of it in the moment. She urged me to be patient, that she would come out okay. So I was patient.

In the meantime Susan began to call me frequently, including using my home phone, which I made clear was for emergencies only, and only during certain hours. She kept the boundary I had set about the hours, but used my home phone to call me about an issue with her health insurance company. When I picked up the phone in my kitchen, I had company and briefly told Susan that I was not free to talk and would discuss this issue with her during her session on Monday. When Monday came, I told her that she should not have used my home phone

for this purpose. She disagreed and let me know that she was angry that I was not available. I tried to reason with her and then realized that she was really regressed and speaking out of the mentality of a needy child.

Once I realized this situation I stopped trying to educate her and simply told her that it was my prerogative to define when I would or would not accept a call at my home, and that insurance company issues definitely did not qualify. Susan complied, but let me know that she thought I was wrong and unreasonable. Though many of our conflicts were played out as subtle or overt power struggles, I never found a way to transform them into anything else. Even when we both acknowledged that we were engaged in a power struggle, it made little difference. It always seemed to come down to what she wanted and felt she needed versus what I was willing or able to give.

Susan also called me at other times, especially on Thursday evenings when my clinical hours were over until the following Monday. At first she was willing to talk for a little while, allowing me to help her with the transition to what was usually a long, lonely weekend for her. But she gradually became more demanding, not wanting to get off the phone, and asking me things like "Don't you have to talk to me if I say I am thinking of killing myself?" Needless to say, I did not find this type of behavior endearing.

I also discovered that Susan had misled me about how much money she had left from her inheritance. One day she informed that she could no longer afford to come unless I reduced the fee significantly. I was shocked and pointed out that she had initially told me something quite different. She simply said I must be mistaken. She knew from the beginning that she could not afford this treatment for any long period of time. She was sure she had told me. But she had not, and I never knew for sure whether she had forgotten that conversation or if she was lying to me. I told her the best I could do at a reduced fee was twice a week, which made her quite angry for a while.

But since her financial circumstances forced her to find a job, her work schedule made it difficult to come even that often. Susan frequently had difficulty leaving work in time to get to her early evening sessions and railed at me for not working longer hours like most therapists. She decided that I was selfish and unwilling to give her what she needed.

There was much more to this case, but a complicated clinical situation like this one could easily be its own book. What I want to focus on here is how Susan's regression quickly became nontherapeutic and

stayed that way, leading to an agreed-upon, but unsatisfactory, termination. All along, Susan wanted me to be her lover, wanted longer sessions, lower fees, frequent phone calls, more convenient session times. Most of all, she wanted me to hold her and rock her. My refusal to accommodate her on any of these issues enraged her and convinced her that she was right and I was wrong.

For my part, I felt martyred in relation to Susan much of the time. I worked hard to help her. I took phone calls from her when I was exhausted and depleted. I felt bad for her, but I often didn't like her. She was consistently seductive with me, which I began to resent as a barrier to any real emotional exchange. Her obsession with having some type of physical contact with me, be it maternal or sexual, inside the session or out, began to grate on me. I was at first frustrated that I couldn't find a way to help her give up this idea, but slowly I became angry, demoralized, and even depressed.

At one point I agreed to sit next to her and take her hand while she cried. She then upped the ante by putting her head on my shoulder. I knew instantly that I had made a huge mistake and gently disengaged from her. At the next session she was buoyant, telling me how great that was, but informing me that I needed to get more comfortable with the whole scenario. Next time I needed to relax. She said she could feel how tentative and tense I was. If this was going to work I had to let go more. (I was immediately struck by how much this sounded like instructions from a more experienced lover to a less experienced one.)

I let her know that I had made a mistake, which I apologized for. I said there would not be a next time—that the amount of physical contact she wanted wasn't something I could provide. She was predictably infuriated.

As I write about Susan I am flooded with all the feelings I had while I was treating her. I feel myself being defensive—wanting to blame her for how difficult things were and how they ended. But I also know that I contributed to our difficult relationship. It was hard for me to make myself vulnerable to Susan because I felt so unsafe with her. One of the things we do not often acknowledge is that the therapist needs to feel a measure of safety as much as the client does.

With other clients I can be defensive when I am first criticized or confronted about some aspect of my behavior. I think it is human nature to do so. But I pay close attention to whether I feel myself cringing inside—a sure sign that whatever my client is saying is probably true. I tell myself to relax, listen, and take the rebuke and the responsi-

bility that is rightfully mine. Stop trying to be perfect and embrace the highly therapeutic scenario of the client telling you how you have erred or done something hurtful—it is your chance to really do what most parents didn't—accept the narcissistic injury of being wrong, admit it, and ask for forgiveness.

This was difficult for me to do with Susan because her demands were so unreasonable. It reminds me of what I say to some of my clients who get into relationships with people who behave outrageously. When they ask me about their roles in these disastrous relationships, I always say that any relationship outcome is the responsibility of both people. But if you enter into a relationship with someone who is notoriously and shamelessly unreasonable, it is extraordinarily difficult to assess your contribution to problems. It is almost impossible to get a read on your own faults and weaknesses because of the overreactions and punitive attitudes exhibited by the other person. Excessive punishment does not invite introspection in another person.

And so it was with Susan. I presented her at a workshop not long after she had terminated to work with another psychologist in town who did body work. One of the therapists in the workshop felt confident that my countertransference to Susan had interfered with her progress. What did I think about that? All I could say was I knew that had to be true, but I couldn't pinpoint how. I had tried to figure this out during the treatment and failed. I knew she reminded me of a relative I had disliked when I was growing up. I knew I didn't find her attractive and that this was evident to her and hurt her feelings and pride from the beginning. (This may have been a reason not to treat her. She needed me to both like her and find her attractive so she could feel less vulnerable and more powerful in the relationship. I think the ideal therapist match would have been someone who liked her more than I did and found her attractive enough, but not so much that her requests for physical contact were too tempting.)

I also knew that I was sometimes too angry with her. I gave her feedback that was sometimes sadistic—like admitting that I wasn't interested in her when she asked me. I felt unduly frustrated by her inability to express deep feelings. I hated being criticized constantly and told what a bad therapist and bad person I was. Furthermore, I know I was feeling vulnerable at the time because my father was ill and I knew he would be dying soon.

Perhaps I was just too narcissistic to handle that much criticism. Most of my clients have appreciated me, even if they were critical at times. Susan said she loved me, but rarely had a good word to say

about me or the treatment during the years she was with me. So maybe I simply can't handle that much negative feedback.

In retrospect, I probably should not have treated Susan because I still have no idea how I could have done things differently to facilitate a better outcome. I was well aware of my countertransference, talked about it with colleagues, and followed my own advice about consulting with the client herself. Yet we cannot always find a suitable remediation for our blind spots and weaknesses. Sometimes we just have to accept our limitations on what we can do and what we cannot do, whom we can treat and whom we cannot treat. Although this therapy produced some significant positive outcomes for Susan—for example, she developed the capacity for fantasy, was better able to identify her feelings, and was able to engage in relationships and work again—the experience was a stressful one for both of us. I imagine she would have been better off seeing someone else, but since she had sex with one prior therapist and was dismissed quickly by two others as "not needing anymore therapy," it is hard to know.

CAN THE THERAPIST CREATE REGRESSION?

There is much debate in the analytic literature regarding the desirability and inevitability of regression, with no real consensus. Some therapists believe that they can create regression, especially the therapeutic type. Yet I have always seen the capacity and willingness to regress as more a function of the client than of the therapist. Granted, a good relationship between therapist and client, for example, establishing basic trust and positive regard, is an essential prerequisite for a therapeutic regression. But I find even the best therapeutic relationship to be necessary, but not sufficient, for regression. I have observed over the years that as the lack of mental health coverage has resulted in my seeing more wealthy people, it has also resulted in my doing less really deep work. I find that many wealthy, successful people make their way in the world by not being vulnerable. No matter how much they might benefit from regressing, they simply don't. It is not how they adapted to the world and is not something they find desirable. If necessary, they will come less often to avoid having the experience of feeling vulnerable and out of control. One self-made multimillionaire stunned himself one day when he began to weep copiously and tremble. He was embarrassed, perhaps humiliated. At his next session he said, "I just came here for a little help with my depression, and then I'll be leaving. Crying is for

losers." Then he laughed. But I knew there was more than a little truth to his joke, and he did leave as soon as he achieved symptom relief.

As therapists we have more power to prevent a regression than to create one. Being too intellectualized, noticeably withdrawing or tensing up when a client expresses deep feelings, will not be lost on her. One client who came to see me said she left her last therapist after less than 10 sessions because when she began to cry deeply her therapist offered her a mint. She was hurt and angry at this misguided attempt to comfort her, and knew this therapist could not help her.

Lastly, the old analytic literature dating from the early 1940s and 50s, when the American medical model of psychoanalysis prevailed, reveals numerous instances of clients regressing to levels of early primitive rage in response to their therapist's silence. As I said previously, most therapists working today are more likely to talk too much as a way of coping with their anxiety, so I doubt that many are inducing this type of "deprivation" rage in their clients. But it is worth a mention since I think it does occur on a microlevel when clients with a history of early deprivation and neglect do not succeed in getting the response they need from their therapists. In that moment, the repressed rage from childhood can be activated quite intensely. In those instances, the best response is active verbal engagement by the therapist, focused on what the client needs.

DANGERS IN REGRESSION WITH TRAUMATIZED CLIENTS

There has been much debate in the literature in recent years regarding the clinical efficacy of having trauma victims relive their traumatizing events in therapy. This controversy goes beyond the scope of this book, but I do want to address a salient point regarding the relationship between regression and traumatization. We know that clients with a history of early abuse regress more easily and are more likely to regress in a nontherapeutic fashion. The neuroscience literature supports this conclusion. Wilkinson (2006) notes that trauma victims are prone to a neuronal response called "kindling," which means that intense emotional reactions are easily activated by internal stimuli "giving rise to flashbacks, epileptic seizures and nightmares."

> Conversely, care must be taken to avoid a situation where patients may unconsciously seek retraumatization in the consulting-room in

> order to experience an endorphin "high" to which they have become accustomed in early and repetitive experiences of trauma. (p. 79)

I only recently became aware of this phenomenon and wonder to what extent I unknowingly re-created this addictive environment in Susan's treatment. The point is not to prevent the client from reexperiencing the emotional pain from the past, but rather to be aware that this potential for retraumatization exists, and to work to prevent it. Educating the client about this potential once such reliving has occurred may also be helpful.

HOW TO KEEP REGRESSION AT MANAGEABLE LEVELS

Although experience helps therapists identify who might be likely to regress in a nontherapeutic way, making this judgment early in treatment can be difficult. Since clients with a history of trauma and early loss are more likely to regress nontherapeutically, a prudent therapist is careful to prevent this through good limit setting, which includes keeping phone calls short and infrequent, starting and ending sessions on time, avoiding special treatment, and not seeing the client more than twice a week. Clearly this last suggestion has less relevance in a world where clients are often seen twice a month. But I think it is worth mentioning nonetheless.

Other factors that can stimulate a nontherapeutic regression include overly probing questions (which can feel like intrusion, or even penetration); too much emphasis on the client's feelings toward the therapist (especially if the client has not brought the subject up); too great an interest in the client's sex life (which can be experienced as seductive); and too much personal information about the therapist (which should be limited with any client). Throughout the remainder of this book I will discuss some of the myriad of issues relevant to maintaining a therapeutic level of regression, and how to get the relationship back on track when the client indicates that some intervention has not been helpful. Generally speaking, however, the best way to avoid a nontherapeutic regression is by following Gabbard's (1994) clinical advice, which I like to paraphrase as "limit setting, limit setting, and more limit setting."

Saying no can be difficult when the client is truly suffering. I think it is almost impossible not to feel the pull to give in to requests for

special treatment during these times, and to feel equally guilty refusing the client's requests under these circumstances. The challenge for therapists is to remain emotionally engaged, feeling both the client's pain and their own guilt, while still compassionately refusing to extend sessions, provide transitional objects, or provide insincere expressions of love or reassurance. These difficult moments are the defining ones in the treatment of disturbed patients. Giving in is easy, but will ultimately compromise the therapy.

The therapist needs to keep several things in mind during the regressed client's mournful pleas for something more. First, since therapists as a group tend to feel guilty and responsible for other people's pain, it can be helpful to remind yourself that you did not create this client's pain and you cannot take it away. It is something the client has to work through herself and learn to manage. Second, there are productive interventions you can use to aid your suffering client. You can provide reassurance that, typically within a few hours, she will feel better. As clients leave the consulting room and go out into the world, they automatically begin to reestablish their defenses. In some cases, this may take a day or more, but the intensity of painful and vulnerable feelings will decline during that period of time. Third, if a fearful client asks what she should do if she does not feel better, or gets worse, you can advise that person to call during the hours you normally check your messages and you will call her back.

Again, these phone calls should be limited and focused on helping the client to understand that the pain she is feeling comes from childhood and feels overpowering because in childhood it actually was. As an adult, she is capable of learning to manage and understand this pain, and you will help her to do so, which is very different than actually taking on that function yourself. Demonstrating confidence in clients' ability to come to terms with whatever their internal experience might be, while admitting that this occurs incrementally over time, acknowledges both the reality of their pain and their potential for managing and even transcending it.

SUMMARY

Regression is a simple and natural process of letting down defenses. It is necessary for any change to take place. How much a client regresses is a result of both early experience and the willingness to be vulnerable. Regression is also determined by the emotional availability of the ther-

apist and her skills in managing regressive experiences. I have outlined the signs of regression, explained how to know whether a regression is therapeutic or not, and emphasized the importance of maintaining boundaries while expressing a calm, quiet acceptance of the client's deep pain.

I provided examples of a therapeutic regression and a nontherapeutic one. Many regressed clients alternate to some degree between these two levels. Clients who have been traumatized may slip from a therapeutic regression into an addictive "kindling" of past traumatic events. Other types of clients may fluctuate between both therapeutic and nontherapeutic regressive experiences. Longer-term therapies are more likely to produce some notable degree of regression. Also clients with borderline personality disorder are more likely to regress early in treatment.

I emphasize the importance of maintaining boundaries and setting limits, even under the most extreme circumstances, because this tactic helps the client learn to control his own affect, rather than turning to others to fulfill this function. It also communicates that the therapist does not feel responsible for the client's pain and believes in the client's ability to learn to manage it.

4

Evaluating Interventions

Tracking the Client's Response

> I am … persuaded by my experience that creating therapeutically helpful comments is a *teachable* skill.
>
> —Paul Wachtel (1993, p. 2)

I was taught by my first analytic supervisor to mentally predict how my clients would respond to my interventions. In his mind, the better I was at predicting, the better therapist I would be. During our supervisory sessions we would discuss in detail what we both observed regarding what the client was feeling and thinking during the hour. We examined how my interventions affected the client through looking at her responses in detail. And we talked about how I might improve my responses when these matters arose in the future. The best news for me was that it was inevitable that important issues would resurface. I did not have to get it right the first time. All clients keep giving us chances, over and over again, to give the right response. Nonetheless, the more accurate we are in predicting client responses, the more successful the therapy will be. Schlessinger (2003) believes therapists should "expect a response to *every* targeted intervention" (p. 227). Furthermore, crafting good interventions, as Wachtel (1993) points out, can be taught.

People *are* predictable in two significant ways. One, we all have established patterns of responding. Two, it is reasonable to assume that a positive response, for example, an accurately empathic understanding of the client, will generate a positive response, and that an intervention that is ill-timed, insensitive, or wrong will have the opposite effect. Yes, we will act and react unpredictably at times, which is part of the

mystery of each individual that we prize. But an ongoing inability to predict how a client *will respond* or to accurately assess how the client *has responded* to an intervention indicates that something is awry. Either the therapist is insufficiently trained, or unsuited characterlogically for the work, or the match is not a good one.

No matter how much therapists might like to believe that they are in a position to evaluate an intervention based on their opinion of its correctness and timeliness, the client is the ultimate authority as to whether or not the therapist's actions were helpful. Correctness of content is irrelevant if the client cannot hear what the therapist is saying, understand its meaning, and use it productively. As Schlessinger (2003) also emphasizes, the client—not the therapist—is the "umpire."

What new therapists need to learn, perhaps more than anything else, is to nondefensively recognize and accept when an intervention has been therapeutic or nontherapeutic. This chapter is devoted to helping make these determinations. The ego-ideal for a therapist should not be the "all-knowing" person, but rather the optimally responsive (Bacal, 1998) flexible person who understands that missing the mark is a step toward mutual understanding. Even experienced therapists struggle with the tendency to defensively ignore the client's indications that an intervention has fallen flat in order to preserve their own narcissistic equilibrium.

If the therapist fails to reasonably assess the client's response to any intervention, she is not in a good position to decide what her next intervention should be. Nothing derails a therapy session more than when the therapist is defending against being wrong and continues to pursue a topic that the client has rejected—or fails to notice that the client has withdrawn and is no longer emotionally available.

Young therapists who are not armed with extensive theoretical knowledge and clinical experience can, and do, achieve therapeutic success. Theories that put the primary emphasis on intellectual processing appear to be at odds with outcome research. Even renowned psychoanalysts like Stephen Mitchell (1997) have acknowledged that what is truly therapeutic appears to have more to do with emotional experience between therapist and client than intellectual understanding.

Clinical experience appears to be an important variable in therapeutic outcome (Luborsky, Auerbach, Chandler, Cohen, & Bachrach, 1971). But neophyte therapists can maximize their successes by focusing more on their client's responses *while in the session*, and less on their intellectual formulations. Extensive intellectual forays into the client's

situation and psychodynamics are important, but are often more fruitfully employed between sessions. In the session itself, emotional availability and empathic responsiveness, while maintaining the therapeutic boundaries, should be the highest priorities. Intellectual insights that spring to mind within a context of steadily flowing emotion are more likely to be relevant and therapeutic.

NOTING HOW THE CLIENT BEGINS THE SESSION

My first analytic supervisor taught me to listen carefully to the first comments my clients make at the start of the session. He said they were very important and would cue me to what my clients needed to talk about. Often the first words refer to the success or failure of the last session, even if indirectly. As Langs (1974) points out, negative references to doctors or other authority figures may well be thinly veiled negative comments about the therapist. Similarly, positive references are also likely to refer to the therapist.

I want to add that negative comments about the therapist's office, the building it is in, the parking, the decorating, or even the therapist's attire are also likely to be expressions of dissatisfaction with the therapy. This is not always true, of course. For example, there is a musical event every week in the park across the street from my building during the summer months. During the late afternoon the parking on my street is closed off and there are sometimes annoying "sound checks" by the bands that will be performing. When my clients express annoyance about these conditions, I am sympathetic and do not take it personally. However, if a client perseverates after I have said I am sorry for the inconvenience or interruption, then I know the cause of his upset is something else. It is likely to be related to the therapy, but may have resulted from something else like a bad day at work. In any event, persistent negative comments cue me to initiate an observation of my client's anger and ask him what he thinks about it.

Some clients need to make a couple of minutes of small talk before they get down to the business of therapy. Often there is a reason for this need that transcends social convention. I have observed that some clients virtually insist on at least 5 minutes of small talk as a vehicle for establishing a connection with me and assessing my mood. Taking my emotional temperature before jumping into the session is self-protective. I have done therapy with many people who

do not give it up no matter how well they know and trust me. So following my first analytic supervisor's advice to listen carefully to the client's first comments may have to wait until this foray into small talk is completed.

Finally, this same supervisor taught me that when a client looks at something in the office that has always been there and says, "Is that new?," it means that some change has occurred internally. The general idea is that the client is unconsciously aware of a new perspective, or level of integration, or insight related to therapy, and spontaneously projects this change onto the therapeutic environment. I have found that clients who are making good progress are the ones likely to say something like "Is that a new chair?" or "That's a nice plant, has that always been there?" The comments are always neutral or positive, of course. And they are only meaningful in this way if no changes, including rearranging, have actually been made.

ASSESSING SPECIFIC INTERVENTIONS

When I supervise therapists I always ask them to think about what the client is asking for, what opportunities to respond they may have missed, and how they will respond the next time. Then I ask them to think about, and attempt to predict, how the client will respond to the intervention we have decided upon in supervision. Initially I illustrate this concept with them by having them audiotape their sessions (the only real way to know what is going on) and I stop the tape after what I think is a particularly good or poor intervention and ask them about it. Then I predict how the client will respond based on my assessment of the intervention. Supervisees are often stunned to see how often I am correct, which is initially a little scary and intimidating, but I emphasize that I can teach them to do the same thing. The process is not as mysterious as they think.

It is rare to see anyone emphasizing this kind of direct reading of the client's response to an intervention, even though I think most experienced therapists would not quibble with Langs's (1973) criteria on a theoretical level. As an aside, however, there are therapists who publish case studies where the client responded to an intervention with a high level of overt distress, questioning the therapist's professionalism or humanity, and the therapist remains convinced that the intervention was a positive one. All I can say to this is that many clients will remain in treatment with a therapist who says hurtful or damaging things,

either because it was an anomaly and the client wants desperately to preserve the relationship, or because the entire relationship consists of a series of sadomasochistic enactments.

Problems can arise when we try to practically apply concepts such as Langs's (1973) reference to "acting out during or after the session," which I will discuss in more detail later in this chapter. The current trend moves away from attempting this kind of assessment, preferring to say that the therapist is in no position to make such a judgment. I feel we cannot make any absolute judgments, but we can certainly make observations infused with skill, training, and experience that we can share with the client. We can say something like, "You seemed to tense up or get angry, or withdraw, after what I just said to you." Then let the client respond.

This type of interaction goes beyond what Langs suggests, in that his determinations are made by the therapist privately, albeit relying on being sensitive and responsive to the client's manifest and latent feedback. He does not recommend an active and ongoing interaction with the client, as I do. The notion of telling the client what you are thinking is part of my own philosophy regarding ongoing collaboration, including checking observations, updating goals, and consulting with the client about any apparent conflicts or impasses that occur. Collaboration and information sharing are at the heart of a relational technique because they respect the client instead of viewing him as weak, sick, or too fragile to handle the truth. They necessarily involve him in every aspect of the treatment, including sorting out what is going on between therapist and client at a given point in time.

Recently a potential client called to ask me to talk about how I work. She said she had looked at my website and saw that I endorsed an interactive psychodynamic approach. She asked me what that meant. I informed her of my basic views on mutuality and collaboration. But I also said that how this translated into action with each individual client depended on her needs and wants. My level of activity is not predetermined, but rather is responsive to my clients' needs. With one client I may mostly listen, ask good questions, and give empathic responses. Some people intuitively understand what they need, and mostly require a therapist with basic skills who will follow along and not get in their way.

Other clients need occasional feedback or advice or confrontation. Difficult clients, like people who have been traumatized, who have borderline personality disorders, or have bipolar disorders, may require constant juggling of a myriad of interventions. Although I am advo-

cating for a certain predictability in clients' behaviors, I am not saying that there is not also a tremendous variety of behaviors that require an equally diverse therapeutic repertoire. Particularly with labile clients, who can move from joy to rage within moments, the therapist must be both flexible and creative.

Therapists cannot know in advance, of course, how a client will begin the session, or what he will be feeling. The predictability should be in *how he is likely to respond to the therapist's intervention, given the therapist's intention.* If I am attempting to help an out-of-control client manage his emotions in the session, then it is safe to assume that my intervention will have that aim. If the client explodes in anger in response to my attempt to help him gain control, then my intervention has clearly failed.

If I ask a question when I want a client to go deeper into his experience, and he clams up and looks away from me instead, I have failed. My goal, however, is not to eliminate these failures, since they are inevitable and instructive, but rather to observe and learn from them. When I supervise new therapists I always tell them that we all fail in small ways every day. Our ultimate success lies in our ability to perceive and respond to these everyday failures. Psychoanalyst Edgar Levenson (1996) elegantly describes the therapeutic function of the therapist's flaws and mistakes: "The patient learns to listen to his/her own small voice through a series of incremental disappointments in the analyst and the analysis" (p. 696).

CONFIRMATORY RESPONSES

Confirmatory responses, of course, are those that validate the therapist's interventions as helpful. Langs (1974) cites the most common forms of genuine immediate confirmations as

> recall of previously repressed thoughts, fantasies, experiences, and childhood memories; the addition of new and fresh material of many kinds; the clarification of previously unexplained problems and symptoms; the alleviation of symptoms and changes in disturbed behavior; the indirect acknowledgment of the therapist's perceptiveness. (p. 81)

Even when the client does not consciously take in and accept a positive intervention, he may let the therapist know he was accurate by referencing some previous time when the therapist was correct. Langs

(1974) says, "Another variation is a reference to someone who is smart, bright, and in tune or knowledgeable in some way" (p. 58).

I think it is generally more important to openly address the client's *negative* response (nonconfirmatory) to an intervention than his *positive* response (confirmatory). Positive responses go almost unnoticed, since they serve to propel the therapy forward. Ideally, they are ongoing small events, so addressing them would be gratuitous. When a client makes the veiled positive reference to an authority figure, as in Langs's example, I have not had much success with bringing this reference to my client's attention.

Verbalizing the idea that the client is probably making a positive reference to the therapist can ironically become a negative intervention. It may cause embarrassment. It may be interpreted as the therapist being needy or too narcissistic. Or it may simply distract the client from what he was about to say next. In these instances, I silently note the positive reference and assume it means that I am on track.

If the client is inclined to directly discuss his feelings of gratitude or experience of symptom relief, I am happy to do so. If the client thanks me for his improvement, I accept his positive regard for my work, but also emphasize that any success is the result of our combined efforts. Again, this encourages clients to take responsibility and ownership, not just for their weaknesses and failures, but also for their strengths and accomplishments.

Another important source of information for the therapist is nonverbal communication. This topic was barely mentioned anywhere in the literature at the time Langs was writing. But the client's silent facial expressions, body movements, and gastrointestinal noises can provide a wealth of information about how she is feeling. The case example that follows later in this chapter addresses a broad range of client nonconfirmatory and confirmatory responses, including nonverbal ones.

NONCONFIRMATORY RESPONSES

Nonconfirmatory responses are negative reactions that indicate the therapist's interventions were not helpful. Robert Langs (1974) provided basic instruction on assessing interventions over 30 years ago—long before psychodynamic clinicians were ready to accept the desirability of doing so. Like Schlessinger (2003), he advises watching the client's response to any intervention carefully. He provides categories of nonconfirmatory responses, that is, indications from the client that the ther-

apist's intervention was not helpful. These include the appearance of acute symptoms, including psychosomatic reactions, both during and after the session; acting out during or after the session; deterioration in ego functioning during and after the session; and clear disturbances in the therapeutic alliance, including tardiness, not showing up for a session, and threatening to terminate.

Examples of acute symptoms during or after the sessions can range from anxiety, to withdrawal, to physical distress, to atypical conflicts with others. The reader may ask how any therapist can reasonably distinguish between symptoms the client frequently has versus symptoms in response to the therapist's interventions. If I am treating a client who came to therapy seeking relief from chronic depression, anxiety, or dissociation, how can I know when those symptoms are the result of a poor intervention? Certainly, the more chronically and severely symptomatic the client is, the more difficult this assessment becomes. Moreover, it is not always possible to know the truth. But if the therapist has established the atmosphere of mutual collaboration and consultation outlined in the previous chapter, assessing interventions becomes infinitely easier.

In the case of Sally, described in Chapter Three as exemplifying a benign, therapeutic regression, it was relatively easy to distinguish between symptoms caused by my poor interventions versus symptoms of regression. If I am not sure why a client is symptomatic, I simply ask what that person thinks about it. In Sally's case, after she regressed she went from being perpetually in motion to not wanting to do anything once she got her kids off to school. She took frequent naps and reported having little interest in seeing anyone. As I stated earlier, her husband became quite concerned about this marked change in her behavior and thought she was getting worse.

When Sally reported these symptoms to me, I discerned they were due to a therapeutic regression. I could sense that she was different. She was not only less frenetic at home, she was much more subdued and emotionally available in her sessions. She stopped running and started feeling. Her sadness was palpable, but far preferable to her defensive talking and self-deprecating humor. Both of us could sense that something important—and positive—was happening.

When a client reports symptoms caused by the uncovering of deep feelings versus therapist error, she does so with little hesitation, feels glad to be in her session, speaks freely, and typically does not feel too concerned. After Sally had reported feeling sad and being listless over a period of many weeks, I asked her if she was feeling burdened by this

phase of the process. She said, on the contrary, she felt liberated by it. It was so nice to feel more at peace, to be more introspective and quiet. But she quickly added that her husband and children were not particularly pleased with her withdrawal, regardless of the reason.

Contrast Sally's reaction to what a client experiences who feels misunderstood, intruded upon, ignored, or rejected. When the therapist has made an error, the client comes to the session feeling more disconnected, withdrawn, possibly out of control, or critical of the therapist and/or the process. There is an atmosphere of tension in the room, and the therapist may be feeling defensive or guilty based on a conscious or unconscious awareness that the previous session did not go well. (Consider the case of Laura reported in Chapter Two who felt deeply rejected by my ungracious receipt of her Christmas gifts.) These breaks in the therapeutic alliance may occur at any time during sessions. They may be overcome, then occur again. As I said, the mark of a good therapist is not being perfect, but rather being agile and quick to recover from inevitable missteps. Once on course again, there is always room for yet another error. If these are not addressed in the session, then there may be the periods of high anxiety, suicidal thoughts, arguments with other people, or psychosomatic symptoms between sessions.

When in doubt, I ask the client what he thinks about what he is experiencing. There are times when I am not sure, so I always just ask. Recently a client had an argument with her husband that lasted for days. She had said previously that he was having trouble adjusting to her newfound ability to control her feelings and seemed to miss her acting out. But because she had such a difficult week, and because her marital conflict began immediately after her last session, I did not hesitate to ask if her distress was related to therapy. She immediately said that it was not. She answered quickly and calmly, while maintaining normal eye contact, which indicated to me that the problem was not between us, but rather between her and her husband. Had I continued to ask about the sessions and her relationship with me (a mistake I have made many times in my career), she would have given me nonconfirmatory responses.

I think we have put too much emphasis on what is unknowable, and too little emphasis on what *is* knowable. As much as we emphasize the likelihood of clients appeasing the therapist, my experience has been that appeasement is reduced dramatically by engaging in a collaborative relationship from the beginning. I find that even the most frightened, approval-seeking clients do not accept my inaccurate inter-

pretations. In an instance when a client is having trouble focusing on emotion I might say something like "Did that make you angry?" If I am incorrect, my comments are greeted with a head shake, a break in eye contact, or a "No"—often followed by the client's correction. Sometimes I get a "Yes, I guess so" (which often means "if you say so"). But these weak confirmations are typically marked not only by lack of eye contact, but also by turning physically away from me, or a further comment of "Maybe, kind of." Clients just won't respond enthusiastically to a nontherapeutic statement.

Weak, pacifying responses aimed at avoiding conflict with the therapist, or due to insufficient self-awareness, lack conviction. The client may think the therapist is observing something he is unaware of and tentatively agreeing to something that is not accurate. Extremely weak and equivocal responses are usually accompanied by nonconfirmatory body language. An observant therapist can potentially identify this type of situation and intervene appropriately. A possible positive intervention is: "It seems I'm a bit off the mark here. Can you help me to better understand what you *were* experiencing?"

How often do therapists avoid this type of consultation with clients because it makes the therapists feel vulnerable? Keeping the therapy on track requires constant monitoring, quick identification of errors, and the ability to change course without feeling inept. New therapists routinely tell me that they do not receive this type of specific instruction regarding working with clients.

Ultimately, this results in them feeling like imposters or frauds. Continuing down the wrong road leaves both therapist and client with a sense of emptiness and unease at the end of the session. The client may even say, "You know, somehow I don't think I got to what was really on my mind today" or "This session didn't seem as good as the last few for some reason." There are other reasons why this type of derailment occurs, of course, but all fall under the umbrella of therapist error or emotional unavailability.

THE CASE OF REBECCA

Rebecca, introduced in Chapter One, started therapy 2 years ago, having moved here to attend law school. She had been in therapy three times previously. As a result she was not only a savvy client, but a skeptical one. She had made limited progress in her previous therapies, and still presented with severe depression, occasional self-harm, a moderate

eating disorder, significant episodes of depersonalization and dissociation, and a profound distrust of others. She had been hospitalized once against her will and was traumatized by that experience. In the first year of therapy, if I said anything about being concerned about her, or asked her about the severity of her symptoms, she would become frightened and ask if I intended to hospitalize her. She was cynical about her prognosis, and about therapy in general, yet still wanted help.

I am using her as a case example for assessing interventions simply because her case is so complicated and her symptoms so pervasive—both within and outside the sessions. Rebecca is reluctant to say how she feels. She is terrified of rejection and abandonment. As a result she avoids conflict with important people in her life at all costs. And she feels humiliated at the thought of needing anyone. Therefore she is reluctant to give me deliberate feedback about any of my interventions, be it positive or negative.

Yet I have been able to track and know how I am doing with her. What helps me to do this is cumulative observations of her particular way of responding. Poker players speak of everyone having a "tell," a facial expression or other physical sign—no matter how hard they try to remain expressionless or still. Good therapists are quick to pick up patterns of responding in their clients and note their "tells" as well as their straightforward responses. (Sometimes the client will become equally skilled in reading the therapist, of course.)

More importantly, Rebecca is making excellent progress, partly due to my daily errors and willingness to admit to them. Levenson's (1994) notion that the "therapist succeeds by failing the patient" (p. 696) can be readily seen in the relief that Rebecca gets from my quick recognition of missteps. Her parents insisted on deference to their authority and never apologized or admitted to mistakes. So it is particularly therapeutic for her that I am willing to do so. For clients like her, the verbal acknowledgment of the inevitable daily therapist failures is critical for success. Other clients may note small errors or mistakes by the therapist without asking for confirmation. As always, the therapist takes her cue from the client regarding what response is required.

Nonverbal Responses to Interventions

Rebecca is frequently silent for much of the session, and I have adapted to her in that I have become attuned to her body language, facial expressions, and frequent gastrointestinal (GI) rumblings. I have been interested that her therapy is the first in which I myself have felt mild

GI rumblings throughout her sessions. I know she experiences deep emotion that she is afraid of showing, which translates into these GI noises, and I have come to the conclusion that my own noises constitute a form of nonverbal empathy. I often experience these rumblings when my clients express deep emotion, but rarely have them throughout a session. Regardless of when and how often they occur, I know that we are sharing some deep feeling during these GI events. So one of the ways I gauge the success of my interventions with Rebecca, and the depth of any session is whether or not we are having this shared nonverbal experience.

Some, but not all, clients will respond immediately with GI noises when an intervention hits the mark. If the client does not reveal what he is feeling, I will usually note the GI response and ask what he is feeling. I have come to appreciate that while the client may not be ready to admit what he is feeling, even to himself, these nonverbal responses are out of his conscious control and serve as a kind of truth detector. However, if the client dismisses his physical response as "nothing," I accept his response and move on. Forcing any type of awareness onto a client who is not ready to feel or know something is nontherapeutic. I simply accept the client's statement and wait for him to say something else. If someone is having GI rumblings because he has missed a meal, or has the flu, these may be mentioned by the client and occur outside of any meaningful interactions. Also, the absence of audible GI noises does not mean that the client is without deep feeling. Although this type of physical reaction is common, it is not universal.

So one way I track Rebecca's experience is through her independent physical reactions and our shared ones. There are many other simple nonverbal reactions that are also very revealing, yet rarely mentioned. All but one of my clients wears a wristwatch, and there is a large clock on a church tower that they can see from where they sit in my office. Over the years I have been amazed, and a bit chagrined, to see how they routinely look at either their watch or the church tower clock when I am on the wrong track, have talked too long, or am disclosing something they do not want to hear. Whatever I am saying, I know it is nontherapeutic when my client checks the time.

A couple of exceptions to this generalization come to mind immediately. Some clients are anxious about the session ending and check the time *for the opposite reason: not wanting it to end.* Sometimes it is because they are not finished talking about something, or wish to begin a new topic but need to see if time allows for it. Checking the time for these reasons usually occurs toward the end of sessions.

Also, there is always the possibility of having a client who idiosyncratically checks the time for a completely different reason, such as an obsessive–compulsive symptom. My response when a client checks the time is to finish my sentence and stop. Or, with clients I have been working with for a long time, simply stop talking in midsentence. I have been amazed at how this action on my part is rarely noted or questioned. Rather than wondering why I have not finished my sentence, the client gratefully switches from my tangential comments to what he really wants to talk about. Directly asking the client if he is bored or unhappy with what I am saying is often not as effective, primarily because the client does not want to hurt my feelings. Clients who are *not* burdened with adherence to social convention will sometimes say things like "You are using up my time," or "I don't want to know all this," or "Can I get back to what I was talking about before?"

When I was a new therapist I found this type of feedback a bit embarrassing and sometimes mildly hurtful. But I soon learned to appreciate my clients' efforts to keep me on track, and to take even harsh responses in stride. I think all new therapists expect too much of themselves and need to come to terms with their narcissistic vulnerability. New therapists are often somewhat grandiose, and this grandiosity extends beyond unrealistic expectations of the therapeutic process. It also necessarily translates into a tendency to overreact to clients' nonconfirmatory responses with hurt feelings, damaged pride, and even shame. Even though most therapists would not verbalize this sense of being wounded, it is registered by the client unconsciously and certainly affects the therapist's subsequent behavior. Silent withdrawal often accompanies a client's rejection of what the therapist is saying.

Shifts in body posture provide significant ongoing feedback to therapists willing to take in this information. I cannot help but notice that when I say something that engages my clients, they cross their legs toward me. When I say something that is incorrect, off the mark, or too threatening, they turn their bodies or cross their legs away from me. This may sound terribly simplistic and obvious, but it seems to me that we do not emphasize this kind of feedback enough.

Returning to Rebecca, she sits further away from me than any of my other clients. I sit on a chair and they sit on the couch across from me. Most of my clients sit on the end closest to me, which also provides an armrest. Rebecca sits about two-thirds of the way down, which means she is much further away and also somewhat uncomfort-

able, in that she does not have an armrest. She barricades herself with the throw pillows on the couch—rarely pushing them aside. Since she maintains this posture throughout the session, it is more difficult to get any cues regarding her body position. Luckily, her constantly changing facial expressions and GI noises fill this void.

Withdrawal and Dissociation

As I mentioned earlier, Rebecca's most frequent defensive maneuver is withdrawal. When she is significantly threatened, she dissociates. She informed me in the first session that she routinely experienced dissociation and asked if I could handle that. I asked her to describe exactly what happens so I could know what to expect. She said when she was out in the world, she found it difficult to walk and felt a strange aura and sense of being outside her body. She had to tell herself to put one foot in front of another so that she could keep moving. In therapy sessions, her eyes glaze over and she "leaves." I said I could handle that, provided she was okay with me checking in to confirm whether she was simply withdrawn or had "left." I also asked if she wanted me to help her return to the present moment when these dissociative episodes occurred or wanted me to wait for her to come back on her own. She said she sometimes had trouble coming back and would like it if I intervened when she was silent for more than a couple of minutes.

I want to remind the reader that I am currently treating Rebecca and have been for almost 2 years. At this point I can report that my interventions have helped to reduce her dissociations to the point that they rarely occur. When I see that something I am saying is causing her to withdraw, I stop immediately. And when I ask her something that is too threatening she will literally wave me off—spontaneously throwing her arm out and across the space between us. When she does this, I know I have to give up whatever I was pursuing. She will often accompany this gesture with a remark such as, "We can't talk about that anymore" or "No, don't say anymore." And, of course, I answer "Okay," or simply stop talking. As time has passed and she sees that I will not be intrusive and domineering, as her mother was, she has given up the extreme measure of dissociating because she doesn't need it. Knowing that I will not force her to talk about anything she isn't comfortable with makes her feel more in control and also more understood. She is able to gain control over her feelings and not resort to dissociation to protect her from internal or external pressures.

Expressions of Negative Emotion versus Nonconfirmatory Responses

It is important to distinguish between the client's indication that a response has not been helpful (which may include anger) versus an expression of anger that occurs because the intervention *was therapeutic.* One mark of Rebecca's trust in me came after about 6 months of therapy, when she started having brief outbursts of annoyance or anger. Since she keeps so much under wraps, it is hard to know what will set her off at a given point in time.

At first I was a bit startled by her unanticipated displays of anger. Gradually I understood that Rebecca's expressions of anger were actually a sign that she trusted me and that she had attached to me. In her case, regression meant not being able to contain her anger as she normally did. In fact, she prided herself on her near-perfect composure in her normal daily life. While I was startled by her anger, she was terrified by it. After a session where she had lost her temper she called and left a voice message begging me to forgive her and not "throw her out of therapy."

It is not unusual for her to become angry when I bring up a painful topic. If this occurs toward the end of a session, and she is still angry as she leaves, she sometimes slams the door on her way out. In the past this action was always followed by the aforementioned excessive apologizing and fears of abandonment. She was astonished that she slammed the door and said it would never happen again. Since she didn't slam it hard enough to disturb anyone in the building or harm the door, I told her she didn't have to be so concerned about it. We always talk about why she was angry and I find her increasing ability to express her anger refreshing. She recently slammed the door as she left and simply called out, "I'm sorry." I called back, "It's okay." And that was the end of it. No self-flagellating phone messages. She knew it really was okay. Although this behavior could be characterized as acting out, I do not believe it interferes with her progress, or indicates a problem in my intervention. It is a small act of defiance that helps her gain her independence from me. Disapproval would only reinforce her fears that I will not really "permit" her to be separate from me.

As I mentioned earlier, a good way to discriminate between a client's negative emotional response, which is often therapeutic, versus a negative response that is nontherapeutic and alienates the client, is by the client's demeanor. Once Rebecca knows I am not angry at her *for being angry at me*, everything is fine and we proceed. She does not start

her next session in a withdrawn or hostile state. If I am in doubt about whether she is angry because I am doing something unhelpful, I simply ask. Here is another recent example from her therapy.

In the past when I pursued the topic of Rebecca's traumatic childhood, which she rarely mentions, she often defended her parents, saying that they did the best they could, and she was not treated well because she didn't deserve better. Levenson (1993) has mentioned the tightrope any therapist walks when dealing with a client who has a strong tie to abusive parents (also see Shengold, 1989). Too much criticism of the parents forces these clients to defensively align themselves with the parents against the therapist "outsider" (Levenson, 1993). So the process of revealing the extent of psychological damage done in childhood, and the very touchy subject of responsibility/blame, needs to be navigated carefully. Too much empathy may threaten the client's personal equilibrium, stirring up intense, unmanageable feelings, as well as desires to defend the parents.

One day Rebecca made reference to her mother's unrelenting criticism, yelling, and general verbal abuse. I said that must have been really terrible to endure every day. She began to cry, but remained silent. I said more. She cried more. After a few minutes, I added another comment about her mother being abusive. She looked up at me and said, "Look, enough is enough. You've made your point. Saying anything more is just plain sadistic." She added that she had already dissolved into nonstop tears, and didn't know what more I was going for. (Actually, I was going for having her break down and sob, instead of just weeping copiously. I was hoping she was ready to lose control with me. But she wasn't and I sadistically expressed my frustration by pushing her too hard.)

I stopped immediately, of course, and apologized. She was still upset but was okay when she left. She let me know she didn't want me to do that again. I said I wouldn't. But as I worked further with her I was sometimes in a quandary. She counts on me to ask questions that get to her pain, and has made it clear that she agrees with me about a good session being one where she feels deeply. But having promised not to go too far in this effort, how do I know for sure when to stop?

Recently we had a "nonemotional" session because Rebecca had an important exam the next morning. I know she sometimes needs the evening after her late afternoon session to recover if we touch on deep feelings. And occasionally she is a bit preoccupied or disoriented in the first part of the following day. So I was careful not to go too deep before this big exam. She asked me why I wasn't pursuing deeper material

with her, and I told her why. I said she needn't worry, we would resume our regular work at the next session.

She came to her next session elated over her success on her exam and ready to resume deep work. Rebecca often writes down things she is unwilling to say out loud. She wrote down that she missed me over the weekend, but felt a mixture of shame, disgust, fear, and anger over having these feelings. I said I was somewhat frustrated by her writing things down that neither of us were supposed to say out loud. Where was I supposed to go with this? She said I could talk about it generally, I just couldn't use the "M"-word, by which she meant "missed." She said if she said that out loud she would feel cut open and like I could just kill her in an instant. We both agreed that our goal was to eliminate these "writing down instead of verbalizing" moments, but she said she still needed them from time to time. Acknowledging her attachment to me is huge, so I participated.

At this point Rebecca and I are sitting looking at each other. She knows that I now know she is very attached to me and afraid I will use this knowledge to hurt her. She wants to go deeper, but is afraid. I want to go deeper with her, but am reluctant because she has chided me in the past for thinking I was too important; is clearly feeling very vulnerable; and has told me that too much talking about her pain can feel intrusive and sadistic. So what do I do? I decided to use her as a consultant and simply present my quandary to her. She responded with her own clarification. She said, "I do like it when you pursue things that are difficult for me. It's just that once I am really crying, then it is time for you to stop. Opening the wound is okay, but if you continue, then it feels like you are putting salt in it. Okay?" I said, "Absolutely. That's clear. And I can do that."

The more I consult with my clients about their reactions to my behavior, the more I understand what is therapeutic for them and what is not. I now know that Rebecca leaving angry is not a big deal—she does so when she is feeling anger from the past, or perhaps because she doesn't really want to leave my office. (This remains unstated, and I would not ask if this is true because of Rebecca's terror of needing me and being destroyed by me. This is something she, not me, would have to bring up.) However, if Rebecca looks angrily at me and criticizes me, or becomes withdrawn and sullen, I have reason to believe that my actions were not therapeutic. And I ask about it. As Ferenczi (1976) said, "In the course of the analysis it is as well to keep one eye constantly open for unconscious expressions of rejection or disbelief and to bring them remorselessly into the open" (p. 221).

ACTING OUT

Langs (1973) comments that "acting out" is a sign that an intervention had been nontherapeutic. *Acting out* is a psychoanalytic term referring generally to feelings and conflicts experienced in the therapy setting that are translated into some type of action, rather than being verbalized and discussed. Acting out has typically been seen as a negative event, but it frequently is done to facilitate the therapy rather than derail it. I am specifically concerned here with *self-destructive acting out* as a response to therapist error.

Self-destructive acting out can include getting into a battle or power struggle with the therapist; getting into an argument with a boss or significant other following the session; leaving the session in a rage at the therapist; missing sessions unnecessarily; having unprotected sex; getting drunk or high on drugs; getting a speeding ticket; or compulsively eating or gambling. I am definitely *not* saying that these client behaviors are always or even usually a result of a poor therapist intervention. I am merely saying that if the client reports excessive symptoms of anxiety or depression, or acting out, it is worth wondering if this *could* be a result of something that happened between therapist and client.

With clients who habitually do these things, of course, it becomes more difficult. For clients who already engage in one or more of these behaviors, it may seem impossible to use acting out to gauge the success of a session. From my experience, it still is useful, because it is a matter of degree. A client who does not normally drink too much, for example, may come to the next session reporting having a hangover and being surprised and chagrined that he atypically engaged in drinking too much. But the client who often drinks too much is likely to make his point by upping the ante and saying he got falling-down drunk after the last session. Baselines are important, and deviations from them are something we benefit from being curious about.

Lastly, as I have mentioned previously, the client's demeanor and willingness to engage with the therapist, regardless of what he has felt or done, is a major indicator of the state of the relationship. A client who has done something self-destructive but is willing to discuss it freely is different than the client who is withdrawn, sullen, or otherwise uncooperative. The latter state can signal that the client's distress is indeed related to something the therapist has said or done.

I also agree with Langs's (1974) comments regarding the breakdown of ego functioning, and certainly any threats to terminate, as signs that something has gone awry between therapist and client. If

the breakdown in communication, or in the relationship as a whole, is not evident to the therapist, I believe it is time to consult with the client. Noting that the client is having difficulties, or is feeling unusually hopeless, or is less involved in therapy, if it is done in an even-handed, noncritical way, can open up a whole new conversation and reestablish the therapeutic alliance.

Langs also mentions psychosomatic complaints as potential nonconfirmatory responses. These can include headaches, body aches, fears of having cancer or some other disease, stomachaches, constipation or diarrhea, or skin inflammations. I want to insert a few comments about what I have observed with some frequency in clients with narcissistic personality disorders. When such a client feels wounded by the therapist, or by a significant other, she may fall ill almost immediately. When I first observed this as a young therapist, I thought I must be mistaken. Perhaps the client was calling in sick and missing an appointment because she was angry with me. But this turned out to be false. Then I thought it must be coincidence. How could a person go home appearing to be perfectly healthy and wake up suffering with high fevers and general malaise only hours later? Is it really possible for a narcissistic injury to fell an otherwise healthy person so quickly and so completely? After repeated observations of this phenomenon, I believe it is. The presence of high fevers, in particular, has struck me as a common thread in these quick-onset bouts of illness. When my client who has been sick returns to therapy it has consistently, but not always, been evident that I had said or done something that was very hurtful to that client. As Freud says, "Sometimes a cigar is just a cigar," and the narcissistically vulnerable client just has the flu. But if the therapist already has a feeling that the last session did not go well, it is worth considering. It is also a good reason not to delay apologizing for a hurtful comment when it occurs during the session. Delaying may cause the person to fall ill when an apology or coming clean on some issue might have prevented it.

BEING SLIGHTLY OFF TRACK

Up to this point I have been discussing how therapists can recognize when the client is confirming the positive or negative impact of an intervention, or even the cumulative impact of a particular session. But what about when the client begins the session clearly upset about some matter, talks about it the entire time, but doesn't seem to get relief?

Training programs tend to focus on helping clients with their immediate concerns. But this may not be the real issue.

I think everyone has had the experience of being upset about something; talking about it to a friend, partner, or even therapist; and feeling somewhat better for having been listened to, yet still feeling agitated. When this happens in a session, the therapist should know that somehow things are off track. If the therapist is being empathic and the client indicates positively that he is being understood, but does not begin to calm down and feel better as the session proceeds, then something is being missed. The client is probably defending against what he is really feeling by being defensively agitated or angry, or is talking about the wrong person. (If the client is having feelings about the therapist, positive or negative, and spends the session talking about someone else, he will get little relief.) If an entire session is spent this way, both people have an odd feeling of dissatisfaction at the end, even though nothing went "wrong." There is a sense of having not quite hit the mark. It is not always possible for the therapist to figure out what is really going on, even when she consults with the client, but whenever the client seems stuck at the same level of emoting about some issue, it is a good idea to think about what else might be going on. (Much of what I say from this point on in this chapter is old psychodynamic clinical wisdom that I learned years ago. Some of it is taught, but for many therapists it comes as new information.) If the therapist cannot figure it out, I advise stopping the client and noting that he does not seem to be getting relief from talking about what is bothering him. What does he think about this?

Sally started her session by saying she needed to talk about her children. This client has discussed parenting issues with me throughout her therapy. Her children's difficulties in adolescence and her overreactions to them was one of her presenting problems, as I noted in Chapter Three. When we talked about her children, I helped her to focus on her role in whatever scenario was being played out, and she was usually aware of her participation.

So when she began her session by saying she needed to talk about problems with her kids, I assumed we would discuss some current conflict and tease out her role in it. Instead, she said she couldn't believe how lazy her kids were. How did she raise such lazy, unambitious children? Over the weekend she told two of them how much it bothered her that they didn't work harder. She also complained that they lacked passion in their lives. Nothing seemed that important to them. Where had she gone wrong? It was obvious that Sally was feeling bad about herself, but since her children have had their share of problems, I still

assumed her negative feelings were related to her tendency to blame herself whenever they did not do well.

She talked easily about her feelings of failure and disappointment. I understood how she felt. Everything seemed to be going fine. Then about half-way through the session I realized we had not really "moved." She was simply restating her feelings, or adding in another example of some behavior of her children that bothered her. But she had not come alive. There were no insights, no sudden realizations of the importance of one particular feeling or event. And she was not getting any relief. Sally was just as discouraged and negative as she was the moment she began talking. Once I noticed this, I realized that even though she often *was* talking about her children, today she was talking about herself. So I said, "Are you feeling particularly bad about yourself today?"

Sally stopped talking. A moment later she said, "Yes, I am." Then I said, "So you are the person you think is too lazy, lacking passion, and hasn't done enough with her life?" She answered, "Yes. I can't believe I was putting all the blame on my kids. Now that you say it, I know you're right. God, I feel bad about this. I think I owe them an apology." She then proceeded to talk about why she was feeling so bad about herself, and the session ended with both of us feeling like we had accomplished something. The content of Sally's session material might strike the reader as quite obvious. Certainly, I always wonder if the client is talking about herself when she spends most of a session talking about someone else's faults. But keep in mind that her children *do* have problems with underachieving and are not particularly passionate about anything, and she sought therapy, in part, to get help instilling more discipline in them. We had often talked about her children with her easy awareness of her participation, rather than her displacing her feelings about herself. So it took awhile for me to see what was going on.

The case of Sharon offers another example that is more involved and took some sleuthing to figure out. Sharon, a middle-aged widow, came for therapy to grieve the loss of her husband and also to express her anger toward him for cheating on her during their long marriage. She was lonely and wanted to get into another relationship, but was also afraid of being hurt. A few months into the therapy, she began dating a younger man whom she had known through various business dealings. She wondered how long the relationship would last, given the age difference. But she also quickly added that she was not that interested in remarrying. She preferred to have a lover and keep her independence.

As their relationship progressed, her lover told her that he was in love with her and wanted to marry her. Yet at the same time he was regularly having lunch with a woman he worked with whom he admitted was interested in him. Sharon decided to take a couple of weeks off and go to her vacation home by herself.

At the first session after her return she seemed depressed and a bit withdrawn. I noted the difference in her and asked if something was bothering her. She said she was fine, but was very unconvincing. Based on my knowledge of her and my own gut reaction, I asked her to talk about how she was feeling. Much of the session was taken up with small talk about her trip and her return. I asked why she hadn't seen her lover, and she said they had both been quite busy. The more we talked the clearer it became that she was avoiding him. I asked her if she had missed him. She said she had not. Since she had told me she loved him right before her trip, I was taken aback by her response. I immediately thought she was in denial, possibly because she was afraid he hadn't missed her or might have been spending time with this other woman. When I asked her about these possibilities, she looked me in the eye and matter-of-factly told me I was wrong.

Now I was really confused. Her easy, nondefensive dismissal of my interpretations told me I was wrong. But I knew I was right that she was slightly depressed and not as forthcoming as she normally was. Frustrated, I finally decided to consult with her before the session ended. I explained my quandary to her. I said I felt confident that something was going on, but all my attempts to ask her outright or to interpret had failed to produce anything meaningful. Could she help me understand? At that point, she looked down with a guilty expression. After a minute of silence, she said, "Well, you are correct. There is something going on. But I didn't want to tell you. I feel too embarrassed, even ashamed. I was hoping to get through the session without talking about it." I said I was relieved to know that my instincts were correct. I let her know that it was up to her to decide whether we discussed it or not. But perhaps she would feel better if she talked about it. Sharon proceeded to tell me she had cheated on her lover while she was away. She felt terrible about it and was afraid I would think less of her if I knew. We continued to talk about her guilt, shame, and thoughts about what she had done. I did not judge her, of course, but rather encouraged her to talk about her thoughts and feelings.

I used the example of Sharon because I think it is not uncommon for a client to either be consciously concealing something shameful, or to suppress it so it is just outside conscious awareness. Whenever a cli-

ent is hiding something important from herself, from her therapist, or both, the end result is a lackluster session. What is hidden becomes the elephant in the room, and very little progress can be made. If the client is actually in the dark, thoughtful questions or asking about dreams may provide enough stimulation to bring the hidden content to the surface. Assessing interventions includes gauging the overall emotional tone and depth of the session. If something doesn't feel right, and the therapist feels as though she is not really getting anywhere with the client, a nonaccusatory form of questioning or consultation can be effective.

"THAT'S A GOOD QUESTION"

Every once in a while a client will respond with a quasi-confirmatory response, usually in the form of saying, "That's a good question" or "That's an interesting question." When I first heard this type of comment, I assumed it was a purely confirmatory response, and some straightforward answer to my question would be immediately forthcoming. However, after many years of noting this response and monitoring what follows, I have come to the conclusion that it is both confirmatory and defensive.

Paul, a longtime client, is very straightforward and honest, yet narcissistically vulnerable and conflict-avoidant with significant others. He can negotiate fiercely in business, yet allows his wife to patronize and insult him in front of their children. His mother was very critical and insulted his father on a daily basis. Paul is ambivalent toward his wife, noting how much she embodies some of his mother's worst traits. Over several years of therapy I tried unsuccessfully to convince Paul that being more assertive with his wife would make things better for both of them. He still believes that being calm and intellectual during conflict is more effective and constitutes an emotional "high road." (Paul illustrates once again the reality that any change the therapist is working toward without the client's full endorsement is unlikely to work.) Paul has made significant progress across the board in therapy, yet retains denial as his primary defense. There have been many occasions when I asked Paul a penetrating question, followed by the response "That's a good question." He then pauses. And I wait for him to respond. As a young therapist, when I heard the phrase "That's a good question" or "That's a great question," I assumed that the client was about to have an "aha" moment.

But Paul, and many other clients who have iron-clad defenses in certain areas, have taught me not to expect much when I hear this phrase. There is no conventional wisdom about what this response means. In fact, I submitted a short piece on the subject to an analytic journal years ago, every reviewer had a different opinion, and the piece was never published. So what I have to say about the "That's a good question" response is the result of my own clinical experience.

I have come to the conclusion that "That's a good question" indicates that the client is immediately defending against something that is true, but denied. He is stepping back and observing and evaluating the therapist's intervention. He is not allowing himself to simply respond emotionally to the therapist's on-target question. From my experience, a moment or more of silence usually follows "That's a good question," rather than the expression of new insight or deep feeling. Following the silence, the client typically changes the subject to something else. When I have said, "Can we go back to what we were just talking about? You said, 'That's a good question.' What were you thinking or feeling after I asked it?," the client says something like 'Oh, I don't remember. (Or, nothing much, really.) I thought it seemed like a good question, but then nothing else really came to mind." So I have concluded that when I get this response from a client I have touched an area that is important, but one that the client is defending against and does not want to discuss. All of this is happening at an unconscious level, of course, which is why no amount of further questioning produces anything of substance.

SUMMARY

Assessing interventions may seem like a daunting task to new therapists. But it is generally possible. A therapist who possesses a good basic understanding of how his clients see and respond to the world around them is in a position to assess how those clients are responding to his attempts to be therapeutic. Most interventions are not spontaneous, and even when they are, it is still possible to observe the impact on the client. And I disagree with those who say a strong negative reaction by a client may result from a good intervention.

Even though it may be humbling for therapists to see how often they are off track, it remains the only way to truly be successful. Accepting daily mistakes as a normal, and necessary, part of the therapeutic interaction helps therapists to be more vigilant and less self-critical. As many of the therapists quoted in this chapter have said, dissonance

brings with it the opportunity for joint communication and understanding. It also serves to deidealize the therapist and lay the groundwork for the emerging independent voice of the client.

No single chapter, or book, can possibly do justice to all the potential responses a client may give. Furthermore, there will always be creative exceptions. But I believe it is possible to generally read what is happening between therapist and client, both in the moment and over time. Knowing when two people are truly communicating with each other, sensing an atmosphere of peaceful acceptance in the face of old pains coming to the surface, is not that difficult, especially in ongoing consultation with the client. The pain resulting from miscommunication, inattention, rejection, or intrusion by the therapist is very different.

Difficult clients who approach the therapeutic relationship with expectations of being misunderstood and even harmed may challenge both the therapist's empathic capacity and assessment skills. But the quandary most therapists find themselves in at that point is, "How do I help this person to see me, and others, as we really are, rather than as she expects us to be?"

5

Self-Disclosure and Advice

Understanding How and When the Therapist's Disclosures Are Therapeutic

> By the analyst's disclosing his own contribution to the emotional experience, he becomes the parent who is willing to take responsibility for contributing to any, even unintentional, emotional difficulty.
>
> —Arnold W. Rachman (1993, p. 93)

Self-disclosure continues to be a controversial topic, with great diversity of opinions expressed in the literature. From my experience, clinicians are not inclined to be forthcoming regarding what and how much they disclose, presumably to avoid criticism. And even those who advocate for disclosure have no real guiding principles for doing so. Self-disclosure is discussed on a case-by-case basis, often with warnings *about not assuming it should be done on a regular basis.* This leaves new therapists confused about whether or not self-disclosure is really therapeutic, and seeing themselves as too inexperienced to make good decisions about implementing it.

Even defining self-disclosure has presented problems. Do deliberate and inadvertent expressions qualify as self-disclosure? Are emotion and information equally self-disclosure? Are other "informational" aspects of the therapist's situation, like style of dress and office décor, considered forms of self-disclosure? More recently "therapist immediacy" has become a synonym for self-disclosure. Since this literature

goes beyond the scope of this book, the reader may check the annotated bibliography at the end of this volume for further references.

For my purposes, *self-disclosure* is defined as any verbal expression of personal feelings or information on the therapist's part, whether deliberate or not. However, I emphasize that impulsive, unexpected self-disclosures are less likely to occur when the therapist is self-aware and does not suppress strong emotional reactions to clients. I do not place the natural facial expressions of emotion on the therapist's face in the category of self-disclosure since these are largely outside of conscious control and are rarely upsetting to the client. Self-disclosure, on the other hand, as a verbalization of something the therapist is thinking or feeling, can have a negative or a positive impact, and can reasonably be within the therapist's control.

Returning to the clinical discussion of self-disclosure, what do we really understand about its therapeutic potential? When is it useful? When is it digressive or disruptive? Who is likely to benefit more, the therapist or the client? What are the motivations for self-disclosing? And can we establish general guiding principles for how and when to use therapist self-disclosure effectively?

New therapists tend to either not disclose at all, for fear of doing it badly, or disclose too much. I want to cite some of the literature, especially the more recent articles, that is relevant to my discussion of self-disclosure. Davis (2002) believes that new therapists are insufficiently aware of the concepts of transference and countertransference. As a result, they do not know how to handle them and tend to self-disclose as a way of imposing reality onto the client and discouraging his developing transference. He suggests that new therapists need more education about self-disclosure so that they are not erring by providing too little or too much disclosure.

Jourard (1971) and Truax and Carkhuff (1965) recommended self-disclosure for the simple reason that their research confirmed the "dyadic effect"—that is, self-disclosure begets self-disclosure. If you want someone to be open with you, be open with him. But their ideas took hold during a period when the culture was leaning toward humanism and egalitarianism. When these cultural notions began to fade, so did the interest in self-disclosure. Psychoanalysts were particularly critical of self-disclosure, considering it to be an intrusion into the patient's intrapsychic world.

Gorkin's (1987) efforts to understand the therapeutic usefulness of self-disclosure were pioneering. He listed confirming the client's sense of reality, establishing the therapist's honesty and humanness, helping

to clarify the impact the client has on both the therapist and others, and breaking impasses. His reasons for using self-disclosure are profoundly utilitarian and no doubt result from his own inductive reasoning. This is what he observed in his own practice and then generalized to others. I agreed with him when I first wrote about self-disclosure 18 years ago (Maroda, 1991) and I still agree with him.

More recently, Myers and Hayes (2006) concluded from their research that the "judicious use" of self-disclosure can be therapeutic. Their findings indicated that self-disclosure worked better when there was a strong therapeutic alliance, but that it was not helpful if it focused on current conflicts or problems in the therapist's life. They warned that therapists may use self-disclosure as a way of gaining approval or seeking validation from the client, which tended to undermine the therapeutic relationship.

Knox, Hess, Petersen, and Hill (1997) concluded that self-disclosure could be beneficial. Again, the disclosure of nonimmediate therapist concerns was received better. They also observed that different clients responded differently to self-disclosure. Although they did not garner enough information to differentiate on this issue, it was clear that for some clients the disclosure of personal information by the therapist blurred the boundaries and made them anxious. Similarly, Meissner (2002), citing Gutheil and Gabbard (1998), warned against burdening the client with personal problems and engaging in a role-reversal. He sees this type of self-disclosure as being nontherapeutic, and I agree.

So even in light of the information obtained from more recent research, there remains the quandary of what to disclose, when to disclose, how to disclose, and whom to disclose to. Little has been done to provide a theoretical framework that would serve as a clinical gauge for answering these questions.

I began formulating my own thoughts about self-disclosure when I was a new therapist. I read the literature voraciously and began to notice that something important happened when there was an overt emotional exchange between therapist and client. At the time, these case accounts were typically discussed in terms of what interpretation would have *prevented* the ensuing emotional exchange. I began to ask myself why should we avoid all emotional encounters with our clients if they were sometimes highly therapeutic and broke impasses?

So after a while I just ignored the conclusions of the authors and closely examined what was reported about the exchange between therapist and client. At the same time, I found that my own clients were often pleading with me to be more honest and open with them. Some

of them desperately wanted feedback or more forceful limit setting and told me outright that the way I practiced was often not helpful to them.

As I chronicled my "experiments" with my clients, I noticed that at certain times I felt great pressure to express my feelings. My training had taught me to ignore this pressure. I was trained to believe that the client was inevitably urging me to do something that would only result in a repetition of negative emotional events from childhood. I was told to remain firm, stoic, and contained.

But I discovered that instead of feeling good at the end of the day, I felt bad. I kept telling myself I was doing the right thing, but I could not shake my patients' call for me to speak more openly and honestly about what I was feeling. I realize that not all young clinicians receive this much strong feedback from their clients. I think I did because I was never really comfortable in the role prescribed for me by analytic tradition, and my clients sensed this discomfort. I think they knew that I instinctively wanted to be more expressive and more engaged with them. They read my face rather quickly because I am an emotional person and wanted me to move from nonverbal to verbal responsiveness. They wanted their realities confirmed. In one sense, my strong empathic nonverbal expressions served as an intolerable ongoing tease to my clients. Clinicians who are less intense and less expressive may well have not provoked such strong appeals from their clients.

So I began expressing my countertransference, focusing on exactly what I was feeling toward the client at that moment. When I digressed and included other observations about the client, or tried to minimize my feelings to avoid inhibiting my client, I discovered that I was not as effective. Talking about myself too much also stalled the process. I find that most clients resent the therapist switching the focus to herself and some will say so.

My fears that my self-disclosures would inhibit my client's disclosures proved to be largely unfounded. In most cases, the client became much more emotionally expressive and matched me in terms of being more candid. Occasionally a client was intimidated by an expression of strong negative affect. But these inhibitory effects typically wore off quite quickly. Encouraging the client to be candid and respond also keeps the dialogue flowing.

From the beginning, my approach had a great deal to do with who I was as a person and what I was stimulating in my clients, as well as what they were stimulating in me. I understood this as I embarked

on my self-disclosure experiments. As I became more comfortable, and more successful, with these interventions, I began to think harder about when, how, and why I was making them. The next question was, To what extent are my results idiosyncratic and to what extent am I working with universal events or phenomena?

I made a deliberate effort to observe what motivated my decision to make a countertransference disclosure. Soon, I realized that I disclosed primarily when the client directly asked or when I was emotionally provoked on a repeated basis. I also disclosed if my client and I had reached some type of impasse, including unrelenting silence. I began to differentiate between the questions that were obviously rhetorical and did not require a response; the questions that were verbalized but without sufficient emphasis for me to assume that an answer was required; the questions that were ridiculing or intrusive in nature; the questions that were innocuous but motivated by wishing to change the subject to something less threatening; and finally, the questions that were heartfelt, direct, and clearly in search of a verbal response.

I understand when people ask me how I can be certain about what category the client's expression truly falls into. Doesn't taking this approach require the analyst to anachronistically revert to the all-knowing authoritarian posture? No, it does not. Understanding what the client wants is more dependent on good listening than it is on omniscience. When I am in doubt about whether or not my client is asking for a disclosure from me, I simply ask for this information. If the client says "No" or "I'm not sure," then I do not answer. "Yes" means I do answer, provided I am comfortable doing so. Epstein (1995) also reports getting similar results from consulting with the client when he is in doubt about disclosing.

At times my struggle over whether or not to disclose was not a conscious verbal one, but rather a stalemate of undetermined origin. Often the client's verbalizations did not jibe with the feelings I was having, but I was definitely having a strong emotional reaction. When this scenario was repeated over time, I discovered that expressing my emotional reactions to the client was highly effective in breaking the impasse and restoring the flow of the treatment. On these occasions, I believe I was receiving a projective identification from the patient, that is, an unconscious communication of affect. (See glossary for definition of *projective identification*.)

I disagree with Renik (1993), who argues that most countertransference is not conscious until it has been impulsively expressed in an enactment. I define *enactment* as an occasion of *mutual* projective iden-

tification that results in some unintended behavior by the therapist (Maroda, 1999). That is, both therapist and client are simultaneously experiencing strong, unacceptable emotions originating in their past and they act these out in their relationship. Enactment occurs when a client unconsciously stimulates a strong, unplanned response by the therapist. For example, a client who is silent for a long period of time may find herself on the receiving end of a sadistic remark by her therapist. Then they are both upset, and often feel guilty. However, it should be noted that to fit the definition of enactment, both therapist and client need to be unaware of what they are stimulating in each other until some untoward event occurs.

I agree that when an enactment occurs, the therapist's countertransference is both strong and unconscious. But it is not the same thing to say *all* strong countertransference reactions are unconscious.

Some enactments are inevitable, and it is impossible to be aware of our countertransference reactions at all times. But from my clinical experience, my awareness of my emotional reactions increased with my willingness to express myself and be curious and nonjudgmental about my feelings, even sexual or violent ones. The more aware and expressive I became, the more aware and expressive my clients became. As a consequence of this greater openness, there were fewer impasses and stormy enactments.

I find that not only am I usually aware of my strong countertransference feelings, so are other clinicians I talk to and supervise. It is the exception, rather than the norm, that strong countertransference feelings are completely out of awareness over time. I think there is a marked tendency for all of us to minimize feelings that could potentially undermine the treatment, such as falling in love with a client, being strongly sexually attracted to a client, or murderously enraged at one. But totally unaware? Not from my experience. The research on affect says that subtle feelings can easily be repressed, but the more intense feelings, particularly intense negative feelings, are less likely to be out of awareness.

We can take this awareness of what we are feeling in response to a client, with due consideration to our own patterns of reacting and vulnerabilities, and apply what we observe to the creation of new techniques. I do not share some of my colleagues' opinions that any attempt to make observations across clients denies the complexity of both the individual and the process. Generalizations can be enormously helpful, provided they are not overapplied and allow for deviations and individual differences.

SHOULD SELF-DISCLOSURE BE SPONTANEOUS?

Renik (1995, 1999) has called for clinical guidelines for self-disclosure, yet puts a premium on intuition and spontaneity in his clinical writing. Even analysts like Renik and Ehrenberg (1982, 1992) who advocate for self-disclosure tend to focus on the human encounter in the moment. I created some basic guidelines for self-disclosure (Maroda, 1991), and am convinced that therapists need to understand how and why their disclosures work. But I have also had considerable success with spontaneous disclosures. How can these apparently contradictory realities be reconciled?

I take issue with what I call the "spontaneity argument." Because of the numerous case reports in the literature involving spontaneity, and because of the limitations of self-awareness, there is a general consensus that self-disclosure cannot be taught or effectively controlled. The preferred stance says therapeutic self-disclosure is a result of intuitive and artistic responses in a unique, creative moment with an individual client.

Although I do not deny that some therapists are more naturally gifted in the areas of empathy, intuition, and creative therapeutic intervention, I strongly disagree with the idea that self-disclosure is dependent on possessing these gifts. If that were true, the percentage of therapists who could use self-disclosure productively would be necessarily small, which I do not believe to be the case.

The belief that self-disclosure cannot be well controlled rests on an outdated belief system about how the brain works. Before much of the current work in neuropsychology, people equated unconscious control *with no control.* On the contrary, behaviors of all sorts, including self-disclosure, that appear to be spontaneous and uncontrolled, are actually controlled by a system of internalized knowledge, experience, and emotional reactions that are primarily unconscious. As Hassin (2005) writes in *The New Unconscious,* "nonconscious control is not only logically possible, it is a psychological reality" (p. 215). In the same edited volume Glaser and Kihlstrom note that "the human mind is capable of maintaining unconscious control over its own automatic processes. This suggests a volitional nature of the unconscious, an idea that to many may seem self-contradictory" (p. 189). What is learned becomes automatic (think about riding a bicycle or playing the piano). Even painfully self-conscious actions are eventually mastered and controlled by unconscious processes.

Given this reality, one can assume that new therapists will neces-

sarily struggle more and be more self-conscious earlier in their training. Eventually everything they learn and practice is stored in the unconscious so it can be retrieved *effortlessly* rather than *effortfully*. This process of storing information in the unconscious, and making decisions based on both emotional and cognitive experience, cannot be logically labeled as outside of conscious control.

Although researchers are not sure exactly how the relationship between conscious and unconscious processes actually works, the best working hypotheses is that automatic and controlled processes work in a relay process between each other, as well as in tandem (Wegner & Bargh, 1998). Uleman, Blader, and Todorov (2005) note that "the appropriate question is not whether something is automatic or controlled, but how much is automatic and how much is controlled?" (p. 373).

New therapists are anxiously overstimulated by unfamiliar situations and scramble to decide what to do. Because their lack of clinical experience dictates that much of their decision making is conscious, they can be literally dizzied by the amount of input they are receiving. Even an experienced therapist, when presented with a new person or a new situation, is likely to experience some anxiety and bring the decision-making process into awareness, rather than act automatically. Conversely, the more experienced, successful therapist is more likely to act comfortably out of his unconscious.

Unfortunately, our tendency to generalize experience has resulted in master therapists believing that they operate in the same manner as new therapists. They do not. Even if an experienced therapist and an inexperienced one come to the same clinical conclusions and implement the same intervention, it is likely that the routes they took during therapy were quite different.

Master therapists, particularly those who have deviated from accepted technique and ventured into different types of self-disclosure, are working from the results of small, repeated experiments. Although this experimentation may be conscious when it first takes place, the accumulated knowledge that is stored translates into unconsciously driven automatic behavior. The master therapist has essentially been building a personal theory based on deductive reasoning. Because his actions *are automatic* he may attribute his therapeutic interventions to intuition.

Donnel Stern (1997) has written about how emotional experiences are often stored in an unformulated way rather than being consciously known and then repressed. Unlike repressed thoughts and feelings, he says, much of what surfaces in therapy has been lying just beneath the

surface, but has never been articulated. He calls this "unformulated experience." He sees this process of keeping thoughts from surfacing as defensive, but I think people often have simply not had sufficient motivation to do the work required to bring unconscious knowledge to the surface.

At an unconscious level experienced therapists know more about what works and what doesn't than they think they do. But for some this knowledge may lay just outside of awareness. So they honestly claim they cannot articulate techniques or even theories. I see this as "unformulated technique" or "unformulated theory." Since consciousness is a continuum, the extent to which anyone knows or doesn't know certain things is relative. Therapists who apply themselves to thinking and writing about their clinical work, or who do clinical research, are examples of individuals who are working hard to bring their knowledge into awareness.

REASONS NOT TO BE SPONTANEOUS

One argument for *not* being spontaneous focuses on the therapist "spilling his guts" when he feels vulnerable. Later in this chapter I elaborate more on the importance of the therapist feeling in control when self-disclosing, but suffice it to say now that there is a good reason why most new therapists are advised to err on the side of caution when it comes to self-disclosure. Especially in the absence of any reasonable guidelines to follow, the new therapist who is emotionally overstimulated is more likely to make a mistake if he does not understand why he is disclosing.

Self-disclosure can be used defensively, and therefore nontherapeutically, just as any intervention can. Therapists who are threatened by the depth of their clients' pain, or dependency, or expressions of love or hate toward the therapist may self-disclose to break the tension. They may also self-disclose to squash the intense feelings the client is having toward the therapist. Overidentification with the client can easily lead to an inappropriate self-disclosure by the therapist. New therapists may be caught off-guard when a client reveals a painful experience that is very similar to something in the therapist's life, past or present. The therapist may be temporarily flooded with thoughts and feelings about her own experience. Ideally, the therapist uses this awareness to enhance empathy with the client, rather than rushing to disclose her own past.

I agree with those who say it is blatant self-indulgence, and essentially out-of-control behavior, on the therapist's part to disclose her experience without any indication that the client needs or wants this. Even questions like "Has anything like this ever happened to you?" should not be construed as an actual need to know. Often the client is simply asking for some reassurance that he is not so odd that the therapist cannot understand or relate to him.

From my experience, even if the client directly asks if you have had similar experiences, what he usually wants to know is whether or not you have ever *felt* the way he feels. It is rare for a client to need any detailed disclosure of the therapist's personal experience. More often than not, the client feels burdened when his question is misconstrued as an actual need to shift the focus from his life to the therapist's. Part of the discipline of doing therapy is working internally to regain perspective and emotional equilibrium after being overstimulated by something the client says or does. Getting relief in the moment by blurting out personal information is likely to be regretted later.

Knox et al. (1997) made the interesting observation that some clients in their study were "voracious in their desire for therapist self-disclosure" (p. 282). Some of these clients went as far as arranging a meeting with the therapist's other clients in order to gain more information about them. I think any therapist would naturally shrink from this kind of "need to know"—recognizing it as an intrusion and attempt to gain power over the therapist. The client who responds to small disclosures with increasing demands is clearly someone who does not benefit from self-disclosure and who experiences it as a boundary crossing or violation. Knox et al. also discuss clients who are fearful of therapist disclosure from the outset because they associate it with blurring the boundaries.

This research clearly illustrates what we already know from clinical experience: you cannot arbitrarily decide to disclose on the basis of client diagnosis, similarity to another client who benefited from self-disclosure, or any other criteria that are not tied to listening to the individual client in the moment.

WHAT IS THE THERAPEUTIC ACTION OF SELF-DISCLOSURE?

Therapeutic action refers to the underlying principles that produce a positive result. When we ask about the therapeutic action of self-disclosure,

we are simply saying, "What is it about self-disclosure that is therapeutic, and is there a manner in which it can be done that maximizes that therapeutic effect?" I want to reiterate how important I think it is to have some solid ideas about self-disclosure before doing it. As I said earlier, the therapist who possesses clinical knowledge and expertise ultimately stores that knowledge and applies it unconsciously. Rather than requiring each new therapist to reinvent the wheel and discover what works and what doesn't through years of trial and error, I think a little education can effectively shorten the learning curve.

Self-disclosure is a simple phrase, but not a simple concept. Dozens of "minitheories" abound in the literature where individual clinicians attempt to account for why a particular self-disclosure was therapeutic. Yet, if it is truly therapeutic, we should be able to identify and articulate an underlying theory that both fuels and frames individual self-disclosures. Once you have a theory regarding the therapeutic action of any intervention, then you can move into the arena of clinical application. The final layer consists of an analysis of the complexities of clinical application, including individual differences, comfort levels, and maintaining emotional equilibrium. Part of this microclinical discussion necessarily involves cautions such as the potential for harm, the cost of misjudgment, and gauging the likelihood of success.

In my opinion, the therapeutic action of self-disclosure consists of three basic, interwoven aspects of human development that center on affect management, reinforcing individual identity, and separation-individuation. This three-pronged overarching theory provides a basic framework that clinicians can quickly reference when thinking about whether or not to disclose, and how to disclose. *First, complete the cycle of affective communication.* I have written about this topic in an earlier work (Maroda, 1999; reprinted in Aron & Harris, 2005) but will briefly cover the basic idea here.

Schore (1994), citing Vygotsky's (1978) work, concluded that "all higher functions emerge as a result of social interaction" (p. 358). Therefore everything that is intrapsychic (within the individual) was first interpersonal. Stern (1985) studied the interactions between mothers and infants, concluding that the infant learned how to emote, when to emote, and how to regulate his or her emotions through repeated exchanges with the mother. When the mother is effective in both mirroring and individually responding to her baby's affect, they are said to be "affectively attuned."

Early affective attunement not only determines the ability to name, express, and contain affect later in life, it also shapes identity and inter-

nal organization. The individual's ability to feel also affects his ability to think. Clore (1994) says that emotion "influences cognitive processing, perhaps in very fundamental ways" (p. 110). Panksepp (1994), citing Gray (1990), states that the "easiest way to light up higher mental processes—of thought, strategies, and conniving—is to activate basic emotional systems" (p. 313). Furthermore, affect patterns laid down in the brain early in life can only be augmented through new emotional experience. *If we take this research seriously, then clearly therapy needs to be infused with an ongoing, manageable degree of emotion in order to facilitate meaningful change.*

I speak about the therapist's role in completing the cycle of affective communication, which involves selectively responding with emotion to the client's emotional expression. The purpose of doing so is to provide the emotional reeducation and assistance with affect regulation that the client did not receive in childhood. Sometimes this means expressing frustration, anger, or sadness, and in this way deviates from the enormously popular notion of primarily providing nurturing and acceptance.

Second, provide behavioral feedback that helps the client to see himself more clearly and situate himself in relation to others. This concept was first elaborated by Sullivan (1953) and more recently has been delineated and expanded creatively by Paul Wachtel. These writers went against the analytic grain of focusing primarily on the internal processes of the individual. Armed with a keen sensitivity to our social embeddedness, Sullivan and Wachtel understood that no individual can meaningfully define himself outside of the social context. Wachtel (2007) speaks about helping the client to see himself from "the inside out and the outside in." When a client says, "How do you see me?" or "What do you see or feel when you are with me?," he is addressing a vital aspect of his core identity.

Ideally, parents, siblings, extended family, and neighbors provide this essential social feedback at an early age. But in an era marked by small families, frequent moves, and nonstop activities, this very personal feedback is often in short supply. Having reached adulthood, this is not the type of question an individual is likely to ask others. Even if he did, it is improbable that he would get an honest answer. Readily available social feedback is typically nonthreatening, consisting of superficial compliments ("Pretty dress" or "Nice hairdo") or unarticulated rejections ("Sorry, I can't make it" or "I'm afraid we're going to have to let you go").

Therapists may be reluctant to give detailed, deep feedback for

fear that their perceptions are too idiosyncratic. They also worry excessively about being hurtful to the client, even when no insult or intense negative statements are involved. Some worry that what they say will be taken by the client as the ultimate truth, and will shut down the therapeutic dialogue. The position I work from is that my clients, at some level, *already know the truth about themselves.* Often for a variety of reasons, they feel thwarted in their attempts to engage others, achieve their goals, and generally position themselves in the world as they had imagined they would. Their symptoms often arise from an inability to be authentic in the world. This echoes Winnicott's (1956) theories regarding the emergence of a "false self" in response to social pressures and reinforcements. But I disagree with Winnicott's emphasis on providing unconditional acceptance and an ongoing "holding" environment as the best route to facilitating authenticity. Instead, I agree with Hirsch (2008) that these empathic functions are overused to avoid conflict with clients.

I do not believe most clients are truly unaware of who they are. Even my most disturbed and withdrawn clients respond with recognition when I verbalize an accurate observation of them that does not fit with their social persona. I believe that disclosing our feelings toward our clients and our perceptions of them, when they have cued us they are ready, provides a more effective therapeutic path to authenticity. Clients are often waiting for us to hold up a reliable mirror that will reflect who they really are, rather than who their parents or society expected them to be. A little digging, or some confrontation, is often needed to break through the defensive wall of the client's repetitive patterns of behavior.

Fears of harming the client when giving accurate behavioral feedback are, to my mind, overstated. A trusted therapist who is off the mark may temporarily upset a client, but I think it is grandiose for any of us to believe that our clients will simply accept our views unquestioningly or be traumatized by an observation that is not entirely accurate. Like any intervention, feedback is best given in a matter-of-fact way that leaves ample room for acknowledging the therapist's bias or error. Any sign that the client is rejecting the feedback should be taken up immediately, encouraging the client to express his honest feelings and thoughts. Authoritarian bullying or judgmental silence are the tools for repression, not even-handed honest feedback.

Third, focus self-disclosure on deidealizing and individuating from the therapist/parent. Through the therapist's admission of error or unfairness, the client gradually realizes that the therapist is not superior as a

human being. As the therapist takes responsibility for her behavior, the client gradually begins to accept the idea that the therapist is flawed. This leaves room for the client to grow and become equal to the therapist in his view of the world, even if the initial deidealization of the therapist is painful. Although this process will be necessarily incomplete, the best-case scenario results in a client who feels more confident, knows who he is, accepts who he is, and is able to leave the therapy without excessive fear or pain.

Deidealizing the therapist and beginning to psychologically separate from her can be painful for the therapist and even demoralizing for her. This is where the therapist has to transcend the everyday human responses of hurt and anger at being criticized—something the client's parents may have failed to do. The more that the client's parents defended against admitting wrongdoing and unfairness, the more important it is for the therapist to do so. The less likely the parent was to apologize, the more essential it is for the therapist to be willing to do so. Each small admission of insensitivity, misunderstanding, lack of attention, or even desire to hurt (provided the client is seeking this acknowledgment) validates the client's experience, encourages his authenticity, reduces the power disparity between client and therapist, and paves the way for autonomy and separation.

BASIC GUIDELINES FOR SELF-DISCLOSURE

Having established the three aspects of the therapeutic action of self-disclosure, we move to the next level: clinical applications. After laying out some basic guidelines, I devote the remainder of this chapter to illustrating these concepts with detailed clinical examples.

Previously (Maroda, 1991) I provided guidelines for self-disclosure that I still use. The exciting research on emotion and attachment has helped me to go further in developing my ideas about self-disclosure and how it works. I refer the reader to *The Power of Countertransference* for a more detailed explication of my thoughts on expressive use of the countertransference. What I basically said then, and still say now, is that the only reasonable way to know when and what to disclose is to follow the client's lead. I listed three basic circumstances where I thought that a countertransference response was called for.

1. *When the client asks directly for a response.* This should not be confused with answering any question the client might ask. Rather, it refers

to a heartfelt request for emotional feedback. The question may refer to the client—for example, "What are you feeling toward me right now?" or "How do you see me?" Or it could be related to something the client is observing in the therapist, and seeking validation for—for example, "You don't seem as present today. Is there something wrong?" The essence of a question that should reasonably be answered is that it is heartfelt and not an attempt to gain power over the therapist. When in doubt, ask the client if he really needs/wants an answer to the question. If the client's answer is equivocal or negative, then I would not recommend answering—at least not without some further exploration of the topic at hand.

2. *When the client is repetitively stuck in an emotional scenario from the past that involves stimulating some strong feeling in the therapist.* By definition, the therapist does not immediately blurt out what she is feeling. It takes time to assess what is going on and to sort out the various emotions involved. I have frequently given the example of the love-seeking client who is actually stimulating anger or some other negative emotion in the therapist. It is challenging for the therapist to respond to a request for love and/or an enduring relationship with an overt expression of frustration or anger. In the case of traumatized or more disturbed clients, the affect stimulated in the therapist is likely to be something the client has defensively split off.

In the past, therapists sometimes blamed the client for stimulating strong emotional responses in them simply because they were uncomfortable and difficult to manage. Understanding how clients may need their therapists to feel and express what they cannot bear to feel and express removes the notion of blame entirely.

3. *Using self-disclosure to break impasses that are not resolved by simply focusing on the client's experience.* I want to note that there can be significant overlap between the second and third reasons to self-disclose. That is, an emotional scenario from the past that is repeated without resolution often results in impasse. But certainly there are other types of impasse as well. Power struggles between client and therapist, or any breach in the therapeutic alliance that persists, clearly constitutes impasse. Furthermore, it is not uncommon for enactment to occur, which I believe consists of the client and therapist mutually acting out some unresolved scenario from the past (Maroda, 1998b).

From my experience, when therapist and client become hopelessly stuck, only a consultation with the client, involving therapist self-disclosure, is effective. However, especially for new therapists, it is best to ensure that the client has had the opportunity to talk through what

he is feeling and thinking before coming to the conclusion that a self-disclosure is required.

Before moving on to case illustrations, I want to make two vitally important points about therapist self-disclosure.

1. *The disclosure of emotion must contain real emotion*. Therapists frequently avoid the vulnerability involved in showing real emotion, saying something to the client like "Are you trying to make me angry?"—which is a backhanded way of saying "I am angry." Therapists who intellectualize, avoid directness, and work overtime to remain cool, calm, and without emotional expression will fail with self-disclosure of affect. If the therapist is feeling too strongly and cannot formulate a brief statement that contains feeling, then he should not disclose. As Margaret Little (1957) wisely said, "Pretended feeling would be worse than useless, but absolute restraint of intense feeling is of no real use either—it is inhuman, and it gives a false idea of the aim of analysis to enable the patient to have and express his own feelings" (p. 244).

2. *The therapist must feel comfortable making the disclosure.* Even if the therapist is comfortable with the specific emotion being disclosed, he may feel he does not trust the client; may feel that too much personal information is involved in the disclosure; may feel guilt or shame about his feelings; or is not confident that the disclosure is in the best interest of the client. As I stated previously, clients will always give their therapists another opportunity. A therapist who is not comfortable with disclosing is much less likely to be successful with that disclosure. Taking time outside of the session to process thoughts and feelings about the client and the situation at hand can be enormously helpful. Talking to a colleague or supervisor may also be needed. There is no shame in not being ready to disclose—especially if the therapist is in doubt about his motivations for doing so.

If the client notices strong emotion in the therapist and asks what this is about, the therapist who is not ready can simply say so. I have found that clients are curious, but understanding, when I say I am having a lot of thoughts and feelings about what they have said, but need to think some more about it before I speak. Modeling good affect management includes the concept that expressing feelings immediately is not always the best choice.

Finally, no discussion of self-disclosure can fail to emphasize the importance of personal style. Since therapists come from different

backgrounds and vary in personality types, it is vitally important to state what may seem obvious: every intervention, including self-disclosure, can only be effective if it conforms to the usual style of the therapist. No matter how many clinical examples one is exposed to, everyone will approach similar clinical situations differently. Each individual clinician can only meet the standard of being comfortable in the disclosure if he or she tailors it to his or her own way of relating. When I speak about guidelines, I do so with respect for the individuality of each therapist and appreciation for the judgment each therapist must use in deciding what to say and how to say it. Authenticity demands that every therapist frame every intervention in his or her own style of speaking and listening. Moreover, every therapist must make his or her own decisions about their clients' readiness—assessing what they can tolerate and use productively.

What follows is a series of case examples, moving from simple, direct self-disclosures to more complex ones that involve multiple interactions and behavioral feedback. These case examples include some of the clients introduced in earlier chapters, giving the reader the opportunity for greater in-depth clinical insights. Again, they contain the language and tone that I use and that reflect my personality.

ANGER

Clients readily read their therapists' facial expressions of anger, even if they are mild (irritation). Later in the book I talk about therapists' tendency to avoid conflict and deny anger, which fails to mirror and validate the client's reality. Admitting freely to irritation or outright anger in a reasonable, straightforward manner can be extremely effective. Rebecca, whom I discussed previously, often had difficulty starting her sessions. One day I was particularly tired and saw her at the end of the day. She had been withdrawn lately and, once again, just stared at me blankly, saying she really had nothing to say. I asked a number of questions, which she answered as briefly as possible. Finally, I just threw her a look that clearly showed my frustration and anger. She anxiously asked, "Are you mad at me?" I responded by saying that I had had a hard day and was definitely impatient with her reluctance to talk to me. I said "mad" was too strong a word, but I was definitely frustrated and annoyed. She relaxed as soon as she saw I was not going to hurt her or abandon her, and we began talking more about her difficulty in

knowing what she was feeling. Soon she was talking about something she had suppressed that was meaningful.

SADNESS

Richard, a client who was also a therapist, noticed one day that I looked sad. Was I, he asked? I freely admitted that I was, due to the illness of a close friend. He said he was sorry my friend was sick, and we both became more energetic and engaged with each other as we talked about the events of his life. As long as the therapist does not burden the client with details about her own life (which ultimately is bad not just for the client but also for the therapist, who will feel guilt or shame later), this brief acknowledgment of the therapist as a human being with feelings and problems of her own can be humanizing for both participants. In my own personal treatment, I noticed that whenever my analyst admitted to what she was feeling, we both felt relief and were able to engage each other at a deeper level. Applying my own experiences with observing my analyst's feelings helped me to understand how disclosure could be helpful to my own clients.

JOY

Although negative feelings in the therapist are noticed more by clients than positive ones, for a variety of reasons many clients want to know they can bring pleasure to their therapists' lives. Or they need to know that the therapist is capable of sharing their joy about a positive event in their lives. Matt, a client I treated for several years, was the most naturally witty and hilarious person I have ever known. He needed to begin each session by making me laugh. If I thwarted him by attempting not to laugh, he was only frustrated and would keep trying. If I allowed myself to laugh, he was then free to explore his own issues. In getting me to laugh he was both giving me something and receiving validation, a sense of safety, and the knowledge that I was emotionally available. Then he felt free to talk.

Cynthia, who loved to write, gave me a piece she had written and said I could read it or not, as I pleased. It was a relatively short piece and I knew, of course, that she wanted me to read it so I would know what a talented writer she was. A few sessions later, she asked if I had read it

and what I thought. I spontaneously smiled and said I loved reading it and thought it was very moving. Clearly she had considerable writing talent. My genuine pleasure produced a corresponding expression of joy on her face and she said she was very happy that I liked her work. In this example, as with all the others, we simply moved on to other things. If a disclosure is effective and timely, as I have stated previously, it is discussed briefly, then serves to open up the session to deeper emotional experience in the client.

THE CASE OF JAMES

James was a busy executive in his late 30s who came for therapy because of marital difficulties. He was suffering from constant anxiety and could not focus, chiefly because his wife had discovered his extramarital affair with a client. James asked for a great deal of information and emotional feedback during our first few sessions. He wanted to know if I could help him with his anxiety. I said I could. He said he felt guilty about cheating on his wife. He had never cheated before and thought only terrible people did something like this. Did I think he was a terrible person? I said no. Then he asked if I could help him erase his intense feelings of being in love with this other woman so that he could do the right thing and return to his wife and children. Again, I said no. I could only help him to calm down, start focusing on his own feelings and experience, and sort out what *he* wanted to do.

This may seem rather simplistic on both our parts. James was admittedly a bit naïve about emotional matters due to having followed more of a social plan dictated by his socioeconomic status rather than having followed his heart. In many respects he was like a young teenager having his first experience with love. Adding on the guilt and shame of being married was overwhelming for him. Even though he handled multimillion dollar accounts and managed a large team at his corporate job, he had an emotional life that was almost adolescent. His extreme distress was genuine. He was so anxious he could not stay still in his seat for more than a few seconds. He fidgeted and moved around the entire time during his early sessions. He asked me these simple questions in all honesty and he benefited from the answers, which reduced his anxiety. Had I asked him what his fantasies were about what I was thinking and feeling (especially since he didn't know me) I feel confident this would have only heightened his anxiety.

THE CASE OF REBECCA

In Chapter One I introduced Rebecca, the very talented but very troubled law student. The reader may recall that she was very afraid of being controlled, and also preoccupied with abandonment. From the beginning of therapy she asked if I would ever hospitalize her against her will. This was a direct question, and she insisted that I give her a direct answer, which obviated the need for any judgment on my part as to whether or not she needed to hear from me. My first internal reaction was that I would not ever want to hospitalize her against her will, but could I really guarantee her that this would never happen? After all, she had had severe bouts of depression and decompensation in the past, which included self-mutilation and suicidal plans.

Although she was clinically depressed and prone to frequent episodes of dissociation when she began therapy with me, she had not yet cut herself (she would do so in a chiefly symbolic way later), nor had she decompensated or made any real suicide attempts. Her mental obsession with suicide had remained exactly that, rather than something she acted upon. I was naturally hopeful that our work together would prevent these difficult episodes, but I was not naïve enough to imagine I could guarantee it. But here was Rebecca, sitting across from me, and saying with great conviction and earnestness, "I need you to reassure me that you will never hospitalize me against my will. If you don't, I can't work with you. I am never going through that experience again."

I didn't respond immediately, and she started getting panicky. "Does your silence mean you intend to do it?" I quickly assured her that I was simply taking a moment to think. Seeing how nervous this was making her, I began to include her in my process. I said I was thinking carefully before I spoke because I didn't want to make any promises I wasn't sure I could keep. What if she became psychotic? What if she said she had a plan to kill herself? Was I to do nothing? I added that I knew she was aware of my ethical and legal obligation to hospitalize her under such circumstances.

Rebecca's forced hospitalization happened because a young therapist took Rebecca's suicidal ruminations too seriously, got scared herself, and called the police. The therapist did this in spite of Rebecca's assurances that she did not really intend to kill herself. When the police arrived, Rebecca calmly told them the same thing. But the young psychiatrist thought Rebecca was lying to stay out of the hospital and told the police to ignore what she said and take her away. This was a trau-

matic event for Rebecca, which intensified her existing lack of basic trust.

I told Rebecca if she was simply asking for assurance from me that I would not get frightened and rush to hospitalize her whenever she expressed suicidal thoughts, this was something I could easily provide. However, if she wanted me to make a blanket statement that I would *never* seek to have her hospitalized—even if she had a plan to end her life or was incapable of caring for herself—that was another story. She quickly said that my first thoughts were correct—she wanted to be consulted and taken seriously. And she wanted to know that I would not be frightened and abandon her during her craziest, darkest moments.

Having clarified the terms, I assured her this would never happen, and we began her treatment in earnest. I realize that a less experienced therapist might not be in a position to make this promise. Nonetheless, under similar circumstances a new therapist could promise to talk things out with the client and do everything possible to avoid any unilateral decision regarding hospitalization. Rebecca wanted and needed to hear from me that I was strong enough to bear her pain. Yet I think she was equally comforted by the knowledge that I would hospitalize her if the circumstances absolutely called for it.

As with all frank, nondefensive conversations, much was gained between Rebecca and myself during this conversation. We both knew more about what to expect from each other. We understood each other's feelings and thoughts about the subject at hand. And we both felt good about our joint ability to be candid and open with each other.

THE CASE OF JENNIFER

I described Jennifer in Chapter One, with reference to asking good questions with regard to her painful breakup with her boyfriend and hidden sexual fantasies about other young women. Recall that when Jennifer began therapy she was severely depressed and contemplating suicide. She had made almost no friends in college and had been clinging to her high school boyfriend to meet her social needs and to ground her. She became suicidally depressed when she realized she was not in love with him and could not marry him. She knew she needed to be free of this dependent, suffocating relationship, but was terrified of being alone. The first 6 months of the therapy centered on helping her to end this relationship and recover from her guilt, depression, and separation anxiety.

Jennifer gradually made new friends, but they were not close. She told me she was one of those kids who never fit in and was teased and rejected by other children. I asked her if she had any idea why other children rejected her and she said she did not, other than in high school when she heard that people interpreted her shyness as snobbishness. Jennifer was very honest and willing to look at the truth about herself, but, like all of us, was not always consciously aware of the truth. She made a point of telling me that she was very bad at social conversation and tended to be highly uncomfortable with other people. I pointed out to her that if she is very uncomfortable with others, then they are likely to be uncomfortable around her. She understood, but said she did not know how to change her personality.

For the next year we worked on her facing her fears of being rejected and ridiculed, and also talked about how she did things to distance herself from other people. Her comfort level with other people improved, but Jennifer was still left with a nagging sense of being different and not fitting in. She was an only child and had parents who were symbiotic, had separate bedrooms, and rarely socialized with anyone. She was adopted and they tended to overindulge and spoil her, while emphasizing that she shouldn't work too hard or attempt difficult things.

She described her mother as whiny and passive—someone she learned to control and manipulate at an early age. Her father was extremely obsessive–compulsive, especially about money. He made her count out the change and place it in his outstretched hand when she returned from the store, even if it was only a few pennies. He doted on her but also enabled her. Her father was critical and patronizing, talking down to her as though she was still a child. He sometimes gratuitously mentioned that she didn't seem to have any real friends.

Several times in the past Jennifer had asked me what was wrong with her: How was she different from other people? Was she crazy? I never knew how to answer that question. I didn't want to make the same mistake I had made with Susan (telling her negative "truths" that would hurt her feelings and alienate her from me). But I could sense that Jennifer needed something more from me. She didn't understand herself and she wanted me to tell her more. To make matters more complicated, I really had no diagnosis for Jennifer, nor did the consulting psychiatrist who prescribed antidepressants for her during the first year of treatment. We both agreed that she defied diagnosis. I had mentioned her emerging homosexuality as the possible source of her feeling so "different," but we both knew it went much deeper than that. Besides, she was never satisfied with this partial explanation.

She had more than a touch of schizoid-type withdrawal, yet could also be hysterical and narcissistic. Her affect was a bit off, but not enough to suspect psychosis. Her awareness of social mores and her social skills were pitifully lacking given her education and socioeconomic status. Yet she could observe herself and did so frequently with a rapier wit.

She was dependent, but could end relationships when they weren't working for her. Her empathy was definitely lacking, but she was capable of attachment and truly caring about other people. So when she asked me what was wrong with her, I really didn't have a straightforward answer, even in my own mind.

Finally, after about 2½ years of therapy, she came into my office one day and said: "Look, I know we've talked about different aspects of my personality and weaknesses that I have, but I just know that I am weird. I'm not like other people. I watch them talking to each other and I can see how different I am. Things that come easily for most other people, like making small talk with people they know, *never* come easily to me. Besides, I can't forget being taunted as a child. I know kids only taunt someone who is really different and weird. I need you to tell me the truth about who I am. What's wrong with me?"

When Jennifer said this to me I could feel myself tense. What she was asking was similar to what Susan had asked, but also different. Both of them exhibited odd behaviors that distanced them from other people. However, I really liked Jennifer in spite of her quirkiness, and I often did not like Susan. Still, I was hesitant to answer her questions. Her father had been cold, controlling, and patronizingly critical of her. I did not want to assume that role, but I didn't want to put her off and treat her like someone who was too fragile to handle the truth either. I wondered what to do.

I sat there for a minute, my mind racing about how to handle this situation. What did I really think about her? What did I like about her? What did I find strange? What did I honestly think about how she got that way? Why was she such a mix of different traits? And what was the bottom line? I searched for an explanation that would be honest, yet not terribly hurtful. In the past, I had used humor to my advantage and suddenly I thought of something to say. "Did you ever watch that television show *Third Rock from the Sun*?" I asked. Jennifer started laughing immediately with recognition. "Yes," she said.

"Well, you're kind of like them," I said. "They aren't crazy, but sometimes they seem crazy to other people because they don't understand a lot of the basic things about human interaction and social mores.

But they are very good observers of 'humans' and can see many of their foibles better than they can. They are also quite endearing in spite of their social awkwardness. That's how I see you. It's almost like you came from another planet and have to start from scratch to learn the rules of this one."

Jennifer thought this was absolutely hysterical and started throwing in her own comparisons. She said I was right on target. That's exactly how she felt. She said, "I've always felt like everybody else got the rule book for life and they forgot to give it to me." After a few minutes of being a bit raucous and silly together, I added more serious comments. I told her that I thought she might be such a mix of different traits, in part, because she is adopted. Since character is a mix of genetic endowment and environmental circumstances, it appears that the two may not have matched up as well for Jennifer as they can when parents and child share a gene pool. I also emphasized that her parents' lack of social skills and their social isolation, the lack of intimacy between them, her lack of both siblings and friends—all certainly played a part in her poor socialization.

When we first started talking she loved the empathy, but then wondered if there was any hope for her. I assured her that there was. It would just take time. Weeks later she brought up this conversation and told me how much it meant to her for me to tell her the truth and how much she trusted me. I didn't placate her, nor did I ridicule her. She said the *Third Rock* analogy was perfect—and hysterical. She kept laughing about it at home.

One measure of the success of my intervention with her was that she stopped asking me what was wrong with her. In the past my reluctant, part answers had always been insufficient. So she would wait awhile, then ask again. Acknowledging the weaknesses we both knew she had seemed to be the catalyst for her improvement. She was determined to overcome her deficits and did amazingly well. Her social skills improved significantly. She made a few friends, then met someone and fell in love. She also asked for advice far less often. Her new love relationship gradually facilitated her separation and independence from me.

She also looked for a new, more challenging job. Once she had set a date for her commitment ceremony with her partner, and was comfortable in her new job, we set a termination date. Although Jennifer's therapy was complicated and involved more than what I describe in this clinical vignette, I believe the feedback I gave her at that time was critical to her therapeutic success.

I feel confident that she still struggles with relationships and with understanding what is socially expected of her. But she also knows that she can be fun, charming, and nice to be with. Her therapy did not "cure" her of her problems. But it did provide the mirror she was looking for. Through my repeated self-disclosures that she requested, Jennifer slowly built up both an understanding of how other people saw her and what she could change to fit in better. She also became more trusting of others and more open as a result of our relationship.

GIVING ADVICE

Whether to give advice is a very delicate issue in psychotherapy. The conventional wisdom is to not give advice at all. But this stance is not realistic and I doubt that any therapist who has practiced for very long can honestly say he has never given any direct advice. I think it is easy when a client asks something like "Should I leave my lover and go back to my wife?," as James did. In such a case, it is clear that the therapist should not answer. The point of the question was that James was experiencing an internal conflict that he did not know how to resolve (although he eventually decided to leave his wife) and *wished* there could be a magical right answer from some authority figure. There is no doubt in my mind that had I answered James's question, he would have completely ignored me, or simply not returned for further sessions.

What I *did* say to him was "Is that what you would like to do?" and "Is that something you can imagine yourself doing?" I like the second question best, because it is difficult to do something that you cannot imagine or dream about first. I like to ask people if they can imagine doing things that they bring up for discussion. His answer, by the way, was that he didn't know what he wanted to do. He couldn't imagine going back to his wife, but he felt he should. James's situation fits the traditional mold of a client who is having trouble making a decision based on an internal conflict and seeks out the therapist as a neutral person who will help him find his own way. Anyone who actually told him what to do would quickly see how unwelcome that response would actually be.

But what about the clients who received little guidance in their formative years who actually need advice from time to time? I find that my young clients, in particular, are prone to asking for both information and opinions from me. Should I be giving advice to them or not?

Rebecca Curtis (2004) did some interesting research, asking analysts what they found helpful in their own treatments. Her results are limited, but did indicate that clients find advice helpful only if they directly ask for it. Unsolicited advice was not welcomed or therapeutic.

WHAT NOT TO DISCLOSE

After more than 25 years of experimenting with and implementing self-disclosure, I have come to some general conclusions about what should not be disclosed. There is a small body of research regarding this issue. In addition to the above-mentioned study by Curtis, indicating that unsolicited advice is usually not helpful, many authors have discussed both the unhelpful and unseemly nature of disclosing current personal problems to clients.

As I have stated previously (Maroda, 1991), sharing personal information in general can become an easy substitute for dealing with emotions. Moreover, information about intimate aspects of the therapist's life, such as marital difficulties, success or failure with finances, career disappointments, or problems with children, is often overstimulating for clients. However, some clients need to know that their therapists have struggled in their lives too. They need to know their therapists are not perfect and can relate to being insecure and even pained. But these clients are not the norm, and even they do not want too much information. I agree with those who say that information about the therapist's personal problems is more likely to be therapeutic if it is revealed within the context of past difficulties rather than current ones. (Wells, 1994; Gutheil & Gabbard, 1998; Curtis, 2004).

Another ill-advised area of disclosure involves discussing current or former clients, even in the most disguised form. Clients who hear a therapist making even oblique references to other clients naturally wonder what you will say to others about them. This is not the same as answering a client's question regarding your clinical experience. If a client says, "Have you treated many people with eating disorders?," for example, that question can be answered without any specific references and is a reasonable question for a potential client to ask. As with much of the advice I give in this book, I have come to this conclusion based on my own past errors. As tempting as it might be to say that you treated a specific individual with a similar problem, no matter how well disguised, it is better to refrain and find another way to convey your point.

Disclosure of pervasive negative feelings, as I did with Susan, who I admitted to disliking with some frequency, is not likely to be helpful. Negative remarks about the client's personality, attitudes, values, or physical appearance are not generally therapeutic. This stands in contrast with the therapeutic potential of expressing negative emotions, such as frustration or anger, during a personal exchange where the client is clearly seeking this emotional feedback. Expressing emotion is very different from critiquing.

An area where I am in disagreement with many of my colleagues centers on disclosure of erotic countertransference. I have discussed this elsewhere (Maroda, 1991, 1999, 2006), but will go into greater detail in Chapter Nine on erotic transference–countertransference. There are many reasons why I believe this type of disclosure is rarely therapeutic.

VOLUNTEERING INFORMATION

Is it ever therapeutic to volunteer information to a client who is not seeking it, either through direct inquiry or the repeated stimulation of emotion? I agree with Levenson (1993) who suggests that certain patients immediately sense when the therapist is upset about something outside the session, tired, or ill—and need this to be revealed to them. I want to add "preoccupied" and less available than normal to that list. This is a difficult judgment, one likely to be quite challenging for any beginning therapist. Certainly, all of us have off-days, or moments when something the client says takes us into our own experience and away from his. I am not suggesting that these moments should be disclosed to the client. I only do so with clients whom I know well. The circumstances for this type of disclosure center on the client reacting with unconscious distress to my own distress or preoccupation.

An example can be seen in the previously discussed case of Nancy, who was hypersensitive to others' availability and quick to assume she had been rejected or abandoned. Over the two occasions I treated Nancy, I noticed that if I was not feeling well or was upset about something, her distress would build during the session. Any attempts on my part to help Nancy identify why she was upset failed. Sometimes she would cycle out of control and start sobbing. Only after I would say something like "I wonder if you are sensing that I am not feeling well today and worrying that my being 'off' has something to do with you?" would she calm down. In the act of calming down, she would often say

something like "I wasn't thinking anything about you, but I feel much better—so that must be right." Then she would usually ask if I was okay. I would answer yes, and the session would continue normally.

After many of these encounters, I gradually learned to tell Nancy at the beginning of the session that I was not up to par, without providing any burdensome details. Invariably, she expressed gratitude for my being forthcoming, and was able to relax and talk about herself. I can only think of one other client who required this of me virtually every time I was not optimally available. But certainly many clients have, at one time or another, said something on the order of "I don't know what's different today, but I just can't seem to get to my feelings." If I know something is wrong on my end, and they say anything having to do with things not seeming quite normal, I will say it might have to do with me. What do they think?

SUMMARY

Self-disclosure has gone from being forbidden to being universally acknowledged as therapeutic in the context of a good therapeutic alliance. Criticisms of the use of self-disclosure have rightfully focused on its lack of theoretical grounding, particularly with regard to therapeutic action. How can we use self-disclosure effectively if we do not have solid ideas about how and why it works? I agree with these criticisms and have attempted here to provide an overarching theoretical framework for self-disclosure, as well as a detailed explication of its clinical applications.

One of the chief problems with self-disclosure resides in the very decision to disclose or not to disclose as a general principle. It is too easy to decide that something is therapeutic, and then use it without sufficient regard for what the client is seeking in the moment. As with all interventions, self-disclosure can only be effective if the client wants it, if the relationship is strong, and if both individuals are able to engage fruitfully about what is happening in the moment.

Certainly, some clients do not seek self-disclosures from their therapists and feel burdened if the therapist initiates it. Others seek some form of disclosure from the very beginning of treatment. For myself, I think it is a sign of progress when a fragile, needy client who is burdened by any knowledge of the therapist as a separate person finally expresses curiosity or concern toward him. But this does not always happen. And therapists necessarily need to assess as best they can

whether their motivations for disclosure center on relieving their clients or themselves.

Utilizing the method of assessing interventions outlined in the previous chapter can help keep the therapist on track. Again, I want to emphasize that making mistakes with self-disclosure are as inevitable as making mistakes with any intervention. Becoming a master therapist involves the ability to nondefensively acknowledge mistakes, apologize if necessary, and continue the collaborative work.

6

Managing Emotion

Affective Communication and the Role of Interaction

> There can be no transforming of darkness into light and of apathy into movement without emotion.
>
> —Carl G. Jung (1969, p. 431)

The critical role of emotion in the transformation of human experience has only recently been recognized. Neuroscience has elevated the topic of emotion, illustrating clearly that it is not the poor relative of cognition. Psychoanalysis has never had a theory of affect, in spite of Freud's awareness of emotional experiences as an essential aspect of treatment (Basch, 1991; Spezzano, 1993). Jung, as seen in the epigraph, was more keenly aware of the essential role of emotion in the change process. But early theorizing naturally fell short of the sophisticated view of the role of emotion in all arenas of life that has emerged as a result of neuroscience research. Several seminal ideas with enormous applicability to clinical work have resulted from our study of the brain. These ideas cover how emotion is stimulated and displayed, how patterns of emotion are laid down in the brain, and generally how these patterns can be altered through new experience.

First, the dichotomy between the conscious and the unconscious mind is a false one. It is true that most decisions are made unconsciously. And it is true that we can spend our lives unaware of feelings and information that have been stored in the unconscious in some form

or another. (See Stern, 1997, for a discussion of "unformulated experience.")

But consciousness is a continuum and both conscious and unconscious processes work in tandem. Moving information and awareness from conscious awareness to the unconscious frees up the conscious mind to learn new tasks and store new information. Since our consciously mediated values, experiences, and preferences are also stored in the unconscious, it can be misleading to suggest that conscious and unconscious are necessarily separate and contradictory.

Second, emotions are social and are mediated from the moment of birth by the caretaker's responses. This emotional homeostasis exists at a level of physical sensation and arousal, as well as within the mind (Stern, 1985; Schore, 1994)—points that are explored further later. Empathy is naturally occurring and is part of the social communication and relational nature of emotion. It is also highly visceral in nature. As stated previously, felt emotion registers on the face and can be masked, but not effectively hidden (Darwin, 1998). People register masked affect, even if only unconsciously (Dimberg et al., 2000).

Third, emotional events are remembered more clearly and longer than nonemotional events (Phelps et al., 1998), with negative emotions being recalled more easily than positive ones. The mind's heavier emphasis on recording and recalling negative experiences is presumed to be innate and tied to basic survival.

Fourth, trauma can be defined as the experience of "unbearable affect" (Krystal, 1988). It is the overwhelming of the individual's capacity to process and contain emotional experience. Therapists often encourage the recall of traumatic events for the purpose of gaining mastery over these overwhelming emotions. But recalling traumatic events has proven to be hazardous as well as helpful. The recall of traumatic emotional events carries the potential for becoming addictive and unproductive. This process is referred to as "kindling."

Finally, the adult brain retains sufficient plasticity, even at older ages, to allow for change. But changing affective patterns in the brain is a long-term process that necessarily involves new, and repeated, emotional experience.

This chapter and the one that follows focus on the critical role of emotion and how therapists can work to help their clients learn to identify, express, and manage their emotions. Working from the relatively new information summarized above creates exciting opportunities for therapists to work differently with clients to facilitate deep and lasting change. After elaborating on some of the important points made in the

affect literature, I provide clinical material that focuses on the potential for both understimulating and overstimulating clients.

GENETICS VERSUS ENVIRONMENT

Although evidence is mounting for what every parent already knows—that each child is born with a certain emotional disposition—environment has an ongoing dramatic impact. Affect and attachment are inseparably joined as the mother begins mirroring the infant's early emotional displays. As the infant moves to initiating independent emotional responses, the mother facilitates, or fails to facilitate, the child's emotional development (Stern, 1985). Schore (1994; Schore & Schore, 2008) has outlined in detail how early attachment determines the infant's capacity for feeling and managing emotions. Griffiths (1997) takes the discussion a step further by delineating the concept of "affect program," which postulates that basic emotional responses are established early in life, laid down in the brain, and recalled automatically.

For decades many therapists and self-help writers have been telling people that they can control what they feel. But the research on affect completely contradicts this popular, and uniquely American, notion. All of the evidence to date says that emotions are triggered through unconscious processes.

Everyone is being stimulated constantly by others around them. There is no way to immunize anyone against these unwanted feelings. Yet this "contagion" factor of emotions provides positive feelings and experiences as well. The only natural immunity that individuals have to being influenced by others appears to be related to identification and attachment. Research has demonstrated that people are more spontaneously and deeply empathic toward others whom they like or respect. And the reverse is true. Nathanson (1996) argues that individuals naturally build up defenses against their empathy toward others in the interests of maintaining their own boundaries and sanity. But our ability to screen out others' emotions is limited, both at the conscious and the unconscious level.

Perhaps the misguided and inaccurate notion that people can control what they feel is based on a need to minimize the impact of powerful others. I always tell my clients that they *cannot control what they feel; they can only learn to manage those feelings and have some reasonable control over how they behave.*

EMOTION PROCESSING AND PSYCHOPATHOLOGY

Although diagnostic criteria often focus on behaviors, it is the emotions that drive those behaviors where most of the therapeutic work occurs. Krystal (1988) has noted that mental illness has traditionally been defined by problems in feeling, identifying, or managing emotion. Davidson (1994) notes that "virtually all forms of major psychopathology involve dysfunctions of emotion" (p. 313). It is not just clients with borderline personality disorders or bipolar disorders who have "emotional problems." Less overtly difficult clients, like those with phobias, problems with self-awareness, and assertiveness, also have affect-based dilemmas. The overly inhibited person is not likely to be labeled as out of control, simply because his emotional restriction creates fewer social problems than someone who is overly expressive. Nonetheless, the person who cannot express deep feelings and cannot be intimate, suffers greatly from the alienation and coldness of his interpersonal world.

Each person learns early in life what is acceptable and unacceptable in the world of emotion. Ekman's (1971) cross-cultural research proved the existence of "display rules," which state that individuals only openly register the feelings that are accepted by their families and their culture. Kemper (2000) reiterates these socially determined rules for expression, noting that what people express from moment to moment is highly dependent on what is considered socially acceptable within the environment. Feelings that are not acceptable are suppressed or split off. (Those who are not successful in inhibiting their socially unacceptable emotional expressions are usually punished swiftly.) Moreover, it is definitely possible for feelings to not only be unconscious, but to be perceived unconsciously by another (Dimberg et al., 2000). This exciting research gives new meaning to the psychoanalytic aim of making the unconscious conscious.

EMOTION AND THERAPEUTIC ACTION

Instead of relying primarily on the recall of painful childhood events (which many people either do not remember or resist remembering), therapists can focus on helping clients to reexperience and manage the emotions from the past. Even traumatic events, like molestation or beating, may not be accessible to recall in terms of the details of the events. Recall of events certainly makes the process easier. But, strictly

speaking, it is not essential to my definition of therapeutic action, based on the affect research.

Memories of early trauma may literally not exist except in the form of emotional memory (LeDoux, 1994; Orange, 1995) because they occurred before the acquisition of language and brain maturation. Even when actual memory of events is possible, some clients simply cannot recall more than snippets or vague sensations of childhood experiences because their emotional traumatization interfered with their information processing. Excessive efforts to recall past traumatic events in clients' lives may not only produce false memories, but may actually have the effect of deemphasizing emotional experience.

Persons who have suffered trauma in their lives tend to be hypervigilant and hyperresponsive regarding emotion. Their past experiences are effectively being "recalled" at an emotional level every day. Dealing with available emotional responses in the present is arguably more effective than focusing on the past. If both are available to conscious awareness, all the better.

As Freud instructed us, everyone inevitably repeats past feelings and behaviors. Affect research has confirmed that patterns of feeling are laid down in the brain during the formative years. These patterns are quickly reignited through exposure to similar circumstances or the stimulation of similar feeling states. As I stated in Chapter Five, new affect patterns can be created, but this requires a consistent effort toward feeling, integrating, and modulating affective states. Behaviorism has been so popular, in my opinion, because it has addressed the critical area of affect management directly. However, there appears to be a contradiction between behaviorism's emphasis on the effectiveness of short-term therapy and that of the affect literature, which states that laying down new neural pathways is a long-term project.

I mentioned earlier in this volume that Panksepp (1994, citing Gray, 1990) discussed how manageable emotion is critical for lighting up the brain and producing higher levels of cognition. Contrary to popular opinion, it is too little or too much emotion that short-circuits cognition. The reasonable conclusion for both therapist and client is that a steady stream of feeling and interaction provides needed recognition and creates the conditions in the brain necessary for change. A therapist who wants to be effective needs to be skilled at promoting manageable levels of feeling within an ongoing therapeutic relationship.

As I consult with other therapists about their clients, inevitably it is the one who under- or overstimulates them whom they seek help with. Not only is all mental illness a problem of affect management,

because therapy is an interpersonal relationship, all problems in treatment are somehow related to affect management as well. Attachment and affective communication are virtually inseparable. Therapist and client are constantly stimulating both wanted and unwanted feelings in each other. The therapist has the enormous task of both managing his own feelings and helping his client to manage hers.

When therapists and clients fail to adequately process the emotions they are stimulating in each other, impasses usually result. But, as I stated in Chapter Five, a broader view of the therapeutic relationship as a vehicle for change, and fueled by emotion and candidness, can help to avoid the impasses that seem so ubiquitous.

FACILITATING MANAGEABLE LEVELS OF EMOTION

Early in most therapy relationships the emotion felt by both members of the therapeutic dyad may be taken for granted. The client tells her story. She may weep and appear shaken and vulnerable. The therapist naturally empathizes, may be tenderly moved by his client's pain, and is inspired to help. As the therapy begins in earnest, both therapist and client are optimistic and initiate the process of attaching to each other. This is clearly the "honeymoon" period that, oddly enough, rarely tends to be thought of as temporary. It is only over a period of time that the therapist, in particular, may begin to notice that his tender feelings have waned. He is not as empathic toward his client as he once was. In fact, he may be puzzled by the boredom that has overtaken him, in spite of his attachment to his troubled client.

With clients who are more out of control, the opposite scenario may occur. The therapist may quickly tire of being so emotionally overstimulated. His client keeps emoting, but doesn't seem to be getting that much better. Lately she has taken to criticizing him and his therapeutic capacities, which is not endearing her to him. He feels exhausted and drained after his sessions with her and wonders if they are really getting anywhere.

In some cases the therapist mysteriously, and perhaps guiltily, gradually loses interest when the client talks about her pain. For example, Dr. S., a compassionate and thoughtful psychodynamic therapist, had been seeing a depressed client for several years. She did well at first, to the delight of both Dr. S. and herself, but then seemed to sink under the weight of her problems. Many therapies go through

a similar honeymoon period where the relationship is very positive early on and the client opens up, feels better, has more energy, and begins to show both symptom relief and insight. She begins to make changes in her life, as this client did, but then sputters and runs out of steam.

Dr. S. described being moved by his client's initial account of her painful childhood and the subsequent difficulties she had had with relationships. What troubled Dr. S. was not just that his client didn't seem to be progressing as time went on, but that he no longer felt the deep empathy for her that he had in the past. In fact, he found himself surprisingly removed and even bored by her repetition of the same narrative. What had happened so that he was no longer moved by her? And how could he help her when he was feeling this way?

Dr. S. experienced something all therapists have faced. Sometimes the client is not really capable of change and was merely briefly enlivened by the excitement of a new relationship where she was understood and accepted. But other times the client has some prospect for change, but gets stuck. From my experience, the client who "hits the wall" needs something more than empathy. Once the client's initial need to be understood has been satisfied, she derives little gratification from retelling the same story. The client who keeps repeating the same lines typically is no longer emotionally engaged herself.

Unlike the early sessions, where the client is full of feeling, she is now devoid of deep emotion. This explains why Dr. S. was no longer moved either. There is no real emotion to respond to. Often the appearance of emotion is merely performative because the client is still suffering and doesn't know what else to do or say. Instead of emoting, she is essentially ruminating in the presence of the therapist just as she has done for years privately. Neither interpretation nor empathy is likely to help her break out of this cognitive and emotional prison.

The challenge for the therapist is how to bring authentic feeling back into the room, because without emotion there can be no change. The recitation of past injuries without the emotional experience gives the therapist nothing to work with. Since empathy is no longer working, and in point of fact the therapist is aware of the lack of empathy in this situation, it is time to change strategies and respond to the client's current need. Sometimes this is difficult because the conflict-avoidant therapist must now find a reasonable way to tell the client that she no longer seems to be feeling much when she talks about herself. What could she talk about that would generate some feeling?

Often clients will ask what their role is and what they can do to facilitate the therapeutic process. A client may begin a session by saying she has several things to talk about, which should she choose? I advise my clients to pick the topic that will generate the most feeling. This is part of how I educate clients about the therapeutic process and explain the role of emotion in change. Then, whenever they are stuck, I ask what they could talk about that might stimulate deep feelings. If they cannot think of anything, I bring up topics that we have identified together as having a high emotional valence.

Felt emotion helps facilitate the process of therapeutic change. Many clients who might resist my empathic efforts to take them to deeper feelings will cooperate more fully once they understand what purpose their emotional vulnerability serves. This can help them to feel less "one-down" when they show emotion, and to be less concerned about the therapist wanting to feel superior to or dominate them. Understanding that showing emotion is the only road to emotional self-awareness, self-acceptance, and self-regulation makes sense to them. Nathanson (1994) reported the same type of collaborative success when teaching his clients with borderline personality disorder about their affective states, particularly their propensity toward feeling shame.

With a client like Dr. S.'s, I would be inclined to gently note that she no longer seems emotionally invested in the stories she tells. With one client I saw, I noted that after numerous repetitions over time, she actually seemed bored and detached herself when she recited past painful events. Did she really feel this way? She quickly admitted that she did, but didn't know what else to say in therapy. She had difficulty staying in the present, and couldn't pinpoint why she felt so bad. So she settled for recounting the past, even though with each narration she was less emotionally invested. I began working with her to better identify daily events that stimulated both positive and negative feelings in her, including her relationship with me.

Some clients fall into a type of complaining, reciting a litany of past hurts, as a way of avoiding vulnerability in the present. Or they may feel that the therapist will lose sight of their suffering if it is not emphasized regularly. Asking what the client is feeling right now, or has felt since the last session, can help focus on recent or here-and-now emotional experiences. Once there is some flow of emotion in the session, no matter how small, there is the potential for both intellectual insight and emotional change.

In clinical situations where the client is often out of control with

emotion, the diagnosis is frequently in the narcissistic to borderline category. Due to the frequency with which impasses, and consultations, occur with this population, I have devoted the next chapter to this topic. The remainder of this chapter will focus on less extreme emotional exchanges.

IDENTIFYING FACIAL EXPRESSIONS OF EMOTION

In my work with Rebecca (introduced in Chapter One), I learned how to deal effectively with someone who is quite emotional, even though she was reluctant or unable to express her feelings verbally. This lack of expression was due to her traumatic history and tendency to dissociate or suppress intense feelings. I also stated earlier that she had trouble starting her sessions and when she got to deep feeling often fell silent. However, her face was quite expressive, and could change rapidly from one emotional expression to another as she sat in quiet reverie.

I have found Ekman's METT (microexpression) and SETT (subtle expression) training tool DVDs on identifying basic emotions invaluable. Ekman's materials train therapists to recognize even the most fleeting facial expressions of emotion (called microexpressions). I use this ability to recognize microexpressions of affect registered on Rebecca's face to work more effectively with her. As I identify her facial expressions of anger, disgust, contempt, happiness, fear, and sadness, I note them out loud to her. Sometimes she knows what I am referring to, other times she does not. In spite of her fears of being intruded upon, she likes that I am paying attention and telling her what I see registered on her face. I say something like, "You just registered disgust on your face. What were you just thinking?" She will then let me know what she is aware of and what she is comfortable discussing. Given her history of emotional and sexual abuse, I never push her to talk if she does not want to.

Using the skills of quickly identifying even the most fleeting expression of emotion that I acquired through Ekman's training has been invaluable not only with Rebecca, but with all my clients. When I announce the affect that they may not be aware of, or are afraid to acknowledge, it often has the effect of affirming and accepting their emotional states. Naming something opens it up and reduces any shame associated with it.

EMOTION AND THE TRANSFERENCE–COUNTERTRANSFERENCE INTERPLAY

Victoria is a new client who has been with me for about 6 months as I write this. She is somewhat narcissistically vulnerable, middle-aged, but quite stable in her life. Married with children, she is also a working professional with a pronounced humanistic, philosophical bent. She is familiar with psychodynamic theory and has always wanted to engage in a psychoanalytic therapy, but only recently decided to do so. The precipitating event was a problem dealing with a coworker at her new job who appears to be a borderline personality. As Victoria began therapy she said she couldn't understand why she let this coworker get to her so much—a constant thorn in her side—and also wanted to talk about how to handle this coworker's intrusive, power-seeking behavior at work. Victoria has a good sense of humor, high intelligence, a strong identity, and the capacity to observe herself. In short, she is the kind of client most people want to have.

I liked her immediately and knew we were a good match. So I was not surprised when she felt the same way. We began once-a-week therapy to deal with her problem at work. Within 5 weeks, that problem predictably faded into the background. We had addressed Victoria's feelings and her reluctance to be more assertive with her coworker, and had talked about how to deal with her more effectively. Victoria also talked about her anger toward this woman, which is a feeling she is reluctant to acknowledge. She likes to think of herself as someone who can be compassionate and understanding with people who clearly have mental health issues. I pointed out to her that she cannot transcend human nature, no matter how tolerant and patient she may be.

As Victoria and I talked each week, it was becoming clear that we were forming an attachment to each other. At first she nervously filled each hour, accepting only a few short empathic comments or questions from me. As interesting as she was to listen to, I wondered how long it might take for her to relax enough to allow me to interact with her and really enter the relationship. With some clients this can take months or longer. But Victoria started to speak more directly to me and look for responses as we jointly discussed how to deal with her coworker.

I want to point out for new therapists that it is a psychoanalytic "given" that external conflicts, even with loved ones, often virtually disappear once the client is fully engaged with the therapist. The idea is that the person's energies and conflicts become focused in the treatment relationship. That is why conflict in therapy is desirable, and also

why some clients may say things like "Everything else in my life is going so well. The only problems I have left are with *You*!" I have seen some young therapists take this to heart and actually believe that they are doing something wrong when, in reality, everything is going as it should.

Victoria, realizing she had stopped obsessing about her problem coworker and that this situation had become almost a nonissue, said she was thinking about coming twice a week for a more intensive, analytic experience. As we talked it became clear that she was ambivalent, yet strangely attracted to the idea of being able to "let go" emotionally and have someone else in charge. Throughout her life, Victoria had been the talented, sensitive, and resourceful person to whom others turned for help. It was both appealing and disconcerting for her to consider giving up this role.

She asked me about coming twice a week at the start of a session. I readily agreed, but oddly enough the rest of the session was rather bland and lifeless. Having changed the premise for her therapy, she had hit "the lull." The next session was also somewhat less engaging, and I thought about how I might intervene to move out of this transition phase. Not surprisingly, the following session marked the beginning of the transference–countertransference interplay and conflict. Victoria began the session by mentioning her son, who was her clear favorite. She described him as tall, handsome, brilliant, and the child she and her husband thought would be the most successful. But lately he had been caught doing some drugs and his grades and behavior in school had slipped. Victoria was worried sick about him, and had mentioned this briefly before.

As the session continued it became evident that Victoria was saddened and confused by her son's behavior. They had always been close, but now he said very little to her. Yet at the same time he managed to be caught easily for skipping school and for having drugs in the house. Victoria said she didn't know what to do. Her son was a good kid and wasn't in any real trouble, and had always needed a lot of attention. Should she be easier on him or harder? Then she recalled recently having purchased something for him right after he had skipped school.

It was in that moment that our conflict began. I had been thinking for several weeks that her son needed more limit setting, and possibly more attention too. When Victoria spoke of what a free spirit her son was, and how his teachers were angered by his sometimes disrespectful behavior, I thought she might be getting too much vicarious pleasure from his behavior. I felt strongly that in spite of being a loving, good

mother in most respects, she was erring on the side of not setting sufficient limits with her son. She said because he had struggled with a learning disorder, she had often felt bad for him and perhaps babied him a bit.

As the session continued, I probed Victoria with questions about her patterns of behavior with her son. The more we talked, the more clear it was that she vacillated between being a disciplined parent with high expectations, to an enabling, overprotective, infantilizing one. I didn't think this was a good combination because she was giving him double messages. I also pointed out that he seemed to be routinely arranging to get caught doing things he shouldn't be doing. Wasn't he trying to get her attention? To my amazement, the normally insightful and thoughtful Victoria resisted any notions that her son needed more from her or that any of her parenting had been inconsistent. As the end of the hour approached, she began to look hurt and angry. Right before the hour ended she looked at me and said, "I'm not a bad mother, you know." I replied, "I know you're not."

When she left the room I felt guilty. At one point during the session she had made some reference to people not liking to be "cross-examined." I knew instantly that she was referring to me and I stopped. But the session was almost over. Why had I continued to question her when it was clear she was not ready to take in some of the realities of her relationship with her son? At the same time, I had this strange feeling that she was goading me and wanted to be in conflict with me. I knew shortly after the session ended that I had overreacted to what I saw as Victoria's parenting errors, chiefly because I had watched my own mother coddle my brother in the same way. Rather than emphasizing his strengths, she played too much to his weaknesses, with predictable results.

While I listened to Victoria talking about her son, I felt the same type of frustration building up in me and the same desire to get her to change her behavior. She sensed my disapproval and felt worse and worse about herself as the session progressed. At no time did I insult or berate Victoria in any way. I didn't have to. My questions and my demeanor told her I thought she was making mistakes. At one point she looked at me and said, "You don't have children, do you?" I felt hurt by this remark and knew she had heard about me from a therapist friend who had read my books. She knew I did not have children. The question was not a real one, but rather a way for her to defend herself. She ended the session feeling bad about herself. I tried to reclaim myself in some small way by looking at her and saying with feeling,

"I know you are not a bad mother." I could see she took this in quite deeply.

This is where I want to stop and ask the reader to think about what happened in the next session. I gave the session a great deal of thought. I concluded that I had behaved badly, gratuitously made Victoria feel bad about herself, yet sensed that somehow we were destined for conflict due to the nature of the psychoanalytic endeavor. I knew she was regressing by the way she looked at me and by her wish to come more often. Had we not had this conflict, no doubt we would have soon had another.

But that fact did not change the circumstances that existed. When the day came for Victoria's next session, I was ready to see signs of her resentment, hurt, and possibly fear of me. She sat down, looked at me, and said she had been having intense feelings since the end of the last session. She mentioned my comment that I didn't think she was a bad mother. She described being overwhelmed with a desire to have me hold her or be close to her. At the same time, she felt like fleeing or hiding. She said that for the first time, it seemed like forever until her next session. In the intervening week she had felt a bit down about herself, and had been angry with me, but wasn't sure why. "How could she be feeling such contradictory things?" she asked.

I inquired about the nature of both her anger and her feelings of wanting to be held and mothered by me. She was embarrassed by the desire to be close and said she couldn't remember ever feeling like that before. Regarding her anger, she said she realized that she resented some of my questions. I reminded her that her last words were "I'm not a bad mother, you know." I asked if I hadn't made her feel like a bad mother by cross-examining her about her parenting. She was quite surprised by this question, and said she had assumed all of these emotions were her responsibility. Now that I mentioned it, she had been angry with me during the session.

Because this woman was strong, and so was our relationship, I took the chance of pointing out to her that she asked me if I had children. Was I wrong in thinking she *knew* I didn't have children and that this was a dig? She wanted me to shut up. What do I know about parenting? I said this matter-of-factly and she responded by laughing nervously. "Gosh, I guess I did, didn't I? I mean I didn't really want to hurt you. I'm sorry if I did. (*Pause*). Or, I guess I did, didn't I? Is that terrible of me?"

I answered no. In fact I apologized to her for my overly aggressive questioning and told her outright that it was a countertransference issue. I went too far and wanted to take responsibility for the outcome.

And I understood completely why she lashed out at me angrily. Victoria responded enthusiastically with "Thank you. Apology accepted." We then went on to talk freely about her fears of getting too close to me and feeling so vulnerable. We frankly discussed how our last session had been a bit messy, but was clearly a sign that we were "mixing it up" and that the therapeutic process had begun in earnest.

I want to note two things about this interaction. First, even though some conflict between us was inevitable and would continue to recur, I behaved primarily out of a preexisting personal issue that dominated Victoria's session. I had to take responsibility for that and she felt emancipated by my doing so. Second, she did not ask what my countertransference issue was, and I did not tell her. There was no sign of any kind that she needed to know, and I strongly believe that I would have added insult to injury had I burdened her with this story from my past. At some point, days, weeks, months, or even years from now, she may ask me what that was all about. If she does, then I will answer to the extent that she inquires about it. If she never asks, I will not ever bring it up.

Each of us took responsibility for our roles in the last session without intellectualizing it or compromising the emotions of which we were both aware. We both were relieved and continued to talk about Victoria's feelings. I was aware that my statement of "I don't think you are a bad mother" was a bit overstimulating for Victoria, but not disastrously so. Applying the previously defined criteria for evaluating an intervention, I should note that Victoria had our interaction on her mind all week, but she did not act out, nor was she symptomatic. She was able to contain these feelings and bring them to her next session.

I consider my reassurance at the end of the previous session to be something I needed to do to reclaim myself. The session was about to end with her thinking I was judging her as a bad mother. As I said earlier, this is not true. So I took the opportunity to say so rather than let her believe something rather negative that does not fit with her self-image, or my image of her. I think leaving her with that for the week would have put her into much conflict not only about her view of herself as a parent, but also about her ability to trust me.

REFLECTING ON THE INTERACTION WITH VICTORIA

I think this case example embodies much of what I have discussed regarding mutuality, collaboration, and the expression of emotion in

an easygoing, everyday fashion. There was no dramatic event or confrontation. More importantly, my assessment and interventions did not display an unattainable degree of self-awareness or require any real creativity.

Without an invitation from me to talk about what happened, including my mistakes or misunderstandings, this content could have easily been buried. Victoria started the next session by telling me how attached she is to me and how strong her feelings are. She also said she felt sad and angry after the session. I could have easily spent the hour with her focusing on her sudden realization of regression and strong reactions to my behavior, as well as her self-identified conflict about her parenting behavior. In other words, she would have let me completely off the hook—because she needed me and didn't want to alienate me just as she was giving over.

As the notion of conflict has receded as a therapeutic goal, the idea of ongoing small *breaches and repairs* as an essential part of the therapeutic relationship seems to have been lost. (See Safran & Muran, 2002, as a notable exception.) Granted, this is most likely to occur in a longer-term treatment. But transference–countertransference conflicts can and do arise even in brief therapies. Understanding both the value of these emotional exchanges and how to navigate them are essential to the repertoire of a successful therapist.

SHARING THE CLIENT'S PAIN

I mentioned in Chapter One that some clients find it difficult to cry or show intense pain because it makes them too vulnerable and may also make them feel embarrassed or ashamed. From my experience, men seem particularly inclined to suppress their sadness and grief. They often become quite self-conscious and uncomfortable when a question or comment from me breaks through their defenses and painful feelings rise to the surface.

As a new therapist I worked not to show emotion on my face, and would simply look at the client with a mildly sympathetic expression. Over many years of experience I have learned to allow my natural emotional responses to register on my face, neither masking nor amplifying them. I was recently working with Mark, a 55-year-old science professor, whose marriage was in a shambles. His wife's primary complaint about Mark was his seeming inability to show any real emotion. He was almost always contained and felt strongly that intellectualization was a superior way of coping. His shows of intense emotion came mainly

after his wife had verbally abused him for hours. Then he would start screaming and yelling at her. When he did this, she told him to leave, but if he made any moves toward the door, she broke down crying and begged him to stay. He usually described these repetitive scenes between them with a mix of frustration, anger, pity, and sadness. They both were in therapy and worked toward improving their marriage, but the death of his wife's best friend intensified her rages at him. Now it was all-out war.

When he came to his sessions he no longer looked like himself. He was losing weight, and looked tired and beaten down. One day he arrived and said he knew he had to leave his wife. The children were being traumatized by her rages, and he had tried everything—usually excessively placating her. But to no avail. As he talked about what it meant to him to lose his home and daily access to the children he loved very much, his face started to tremble and his tears came streaming down. He quickly put his hands over his face, and cried hard. As he wiped away his tears, he briefly looked over at me. Clearly feeling vulnerable, he looked to see how I was receiving his pain. His feelings were so intense that my eyes were moist with tears and my face registered his pain. With that, he broke down sobbing, telling me how much he loved his family and how hard he tried to make things work.

The pain of this normally stoic, but emotionally intense man was almost unbearable for me. As he cried, a few tears ran down my face, and I had a strong visceral reaction. My guts felt like jelly and I worked to stay calmly in my seat and not say anything. Mark grieved intensely for a few minutes. Then, as many men do, he wiped away his tears with his hands and shirtsleeves rather than reach for the tissue on the table.

After Mark composed himself, he went on talking about his broken marriage and how tragic it was to him. He saw me reach for a tissue and use it. Then he said, "Is the therapist supposed to cry, too?" with a little laugh, but also with a note of concern about whether or not I was able to maintain my professional stance. I said, "Well, sometimes we do, and sometimes we don't. But it's okay if we do." When he saw that I was still functioning in my therapeutic role, he was relieved and went on talking.

If I had looked alarmed by his intense, uncharacteristic, and primitive show of emotion, surely Mark would have stopped crying immediately. And since it was difficult for me as an experienced therapist to sit quietly while he was wracked with sobs, I can only assume that this scenario would be challenging for any new therapist. The only way I could remain present was to let out some pain myself, which was fine once Mark knew I had not given up my authority.

SUMMARY

Being more aware of the realities of affective communication, as well the intense countertransference feelings that are routinely stimulated in therapy, can help new therapists to deal more effectively with their clients' affects and their own. Rather than seeking to provide only understanding and comfort, new therapists may miss the opportunity to engage in productive, manageable conflicts and reparations. Self-awareness, the confidence that maintaining a moderate flow of emotion is therapeutic, and a willingness to admit to bias, errors, and insensitivities all contribute to a fruitful and ever-changing relationship. Being attuned to the subtle facial expressions of emotion also facilitates awareness of the client's emotions, whether or not they have been expressed.

The ability to sit with another person while he feels intense, almost unbearable, sadness and pain may become a lost art. Facilitating the expression of pain without pitying or rushing to comfort the client requires a belief that grieving is at the heart of the therapeutic process. Training programs that increasingly emphasize homework, relaxation, and minimizing negative thoughts do little to prepare new therapists for the realities of the "black hole" and endless despair that many clients express. Negative thoughts tend to diminish when clients are free to express their anguish.

Rare exceptions to the value of self-expression include the aforementioned "kindling" response to recalling trauma, as well as unchecked "emotional storms" in clients with borderline personality disorder. The next chapter is devoted to discussing borderline personalities and the unique challenges they present with regard to affect management.

7

The Special Problem of Affect Management in Treating Borderline Personality Disorders

> Borderline patients are exquisitely humiliation prone. They have a pronounced tendency to experience others as deliberately inflicting shame on them.
>
> —Melvin R. Lansky (1992, p. 37)

Treating clients who tend to be emotionally out of control presents unique challenges and stresses for therapists. Particularly challenging is the client who is hypervigilant and hyperresponsive, alternating unexpectedly between strong positive and strong negative emotions. These clients usually suffer from some personality disorder—often borderline personality disorder, or BPD. This diagnostic term has fallen out of favor in recent years because it has been used so pejoratively. Some clinicians feel it is an insult to even mention this diagnostic category. Summers (1999), who discusses disturbed clients with great compassion, has suggested replacing the BPD designation with *"fragile personality."* I understand and appreciate the intentions of these efforts, but consider them futile. "Borderline" is not an inherently insulting word. It became one because of the intense anger, despair, and hopelessness that therapists so often feel in the course of treating these clients. When one says *borderline* with an angry sneer, it is the expression of negative affect that makes it an insult instead of a diagnosis.

I believe that the same negative countertransference feelings can, and probably will, be attached to any new diagnostic term. For this rea-

son, and for the convenience of shared knowledge of terminology, I am using the term borderline personality disorder (BPD). It goes without saying that I do not endorse an angry or dismissive attitude toward these clients, who come by their emotional distress honestly and who are in deep need of skilled therapists.

From the standpoint of affect research, the most serious problem with the DSM-IV-TR definition of BPD is not what it says, but what it leaves out. The newest findings regarding the role of emotion in this diagnostic group are discussed throughout the remainder of the chapter. The literature review presented in this chapter is selective, pertaining only to the clinical issues presented here.[1]

NATURE OR NURTURE IN BORDERLINE PERSONALITY?

Increasing evidence suggests that the disposition toward emotional intensity and variability seen in persons with BPD is genetic (Linehan, 1993). Substantiating what many therapists have thought for some time, brain activity appears to be different in clients with BPD, even though we do not know the causes of these differences. Gregory and Remen (2008, p. 15) report that "neuroimaging studies have demonstrated that BPD is associated with dysfunction and/or atrophy of multiple areas of the brain" (Lieb, Zanarini, Schmah, Linehan, & Bohus, 2004). They say the affected areas have diverse functions, including "memory, arousal, emotion processing, attribution, and decision-making" (p. 15).

Any therapist who has experience treating clients with BPD will attest to the fact that these clients often disagree strongly with the therapist and others who recall past conversations and events quite differently than they do. In the past it has been easy to attribute these differences to the need of clients with BPD to manipulate and even lie, if necessary, to distort reality in their favor. Although no one is beyond distorting reality somewhat for his own benefit, the issue of cognitive impairment in clients with BPD needs to be addressed more seriously. The difficulty of the client with BPD in understanding what the therapist is saying at any moment in time may also be related to temporary or permanent brain dysfunction rather than stubbornness or the desire to distort reality. Therapists in general may be too quick to attribute the

[1] The literature on BPD is voluminous and beyond the scope of this book. However, some relevant references are listed in the annotated bibliography.

behaviors of clients with BPD to manipulation rather than to an honest problem with reality testing and cognitive processing.

There is insufficient information to determine how much of the emotional intensity and tendency toward "emotional storms" of the client with BPD comes from nature or nurture. Interestingly, Trull (2001) concluded that parental psychopathology was *not* a significant etiological factor, but some type of physical or sexual abuse was frequently present. The universal BPD features were disinhibition (impulsivity) and negative affectivity. Because of the frequency of everything from repeated abandonment threats to sexual abuse in the history of clients with BPD, the assumption made by some is that all clients with BPD have suffered some trauma.

But Graybar and Boutilier (2002) refute that notion. They cite Gabbard's (1996b) research stating that between 20 and 40% of clients with BPD have *no* history of abuse. They also reported that Fossati, Madeddu, and Maffei (1999) could not conclude that childhood sexual abuse was a "major risk factor or antecedent cause of Borderline Personality Disorder" (p. 153). Their article is devoted to a discussion of the "significant minority" of clients with BPD who have no history of abuse.

Graybar and Boutilier (2002) delineate four nontraumatic pathways to BPD pathology. The first three pathways all relate to inheritability and temperament, both for neurological impairment and for hypersensitivity. The fourth nontraumatic path is maternal substance abuse. Nontraumatized clients with BPD share the same affective and relational instability as their traumatized counterparts, but may require different treatment approaches. It is essential to keep in mind that even those clients with BPD who have not suffered trauma do suffer from a significant attachment disorder that dominates their emotional lives. Schore and Schore (2008) say:

> Watt (2003, p. 109) observes, "If children grow up with dominant experiences of separation, distress, fear and rage, then they will go down a bad pathogenic developmental pathway and it's not just a bad psychological pathway but a bad neurological pathway." This is due to the fact that during early critical periods organized and disorganized insecure attachment histories are "affectively burnt in" the infant's rapidly developing right brain (Schore, 2001a, 2001b). (p. 12)

These patterns may be altered in psychotherapy through the repetition of new emotional experiences. Affect management and an emotional reeducation is the primary task for any therapist treating

clients with BPD. Graybar and Boutilier (2002) note the frequency with which therapists search for repressed memories in clients who have not suffered any trauma. They state further that clients who appear to have significant problems with neurological processing may fare better with supportive treatment rather than with intensive psychodynamic work, which requires a level of cognitive processing that may exceed their cognitive capabilities. These multiple paths to the diagnosis of BPD speak to the broad array of clients who fall into this diagnostic category and the need for individualizing both prognosis and treatment.

Clients with BPD are frequently the most, or only, overtly abused child in their household. I have had several clients with BPD describe being puzzled as to why they were consistently chosen as the object of their parents' out-of-control emotions. I think this can be accounted for by their inborn emotional intensity. Since they are typically strong-willed, emotional, and even passionate as children, they can serve as "lightning rods" for emotionally unstable caretakers. It is not unusual in their histories for them to have stood up to abusive parents, which often resulted in even more abuse. When clients with BPD say "Why me?," the answer may be because they naturally drew attention to themselves through their emotional intensity and/or perceived strength.

REINTRODUCING NANCY AND REBECCA

Nancy is the client, introduced in Chapter One, whom I treated twice, with an interval of 20 years. These two treatments with the same person were highly educative for both of us. Recall that I ended up telling her that I resented and even hated her sometimes. I told her that in spite of her protestations to the contrary, I did not feel loved when she repeatedly berated me for not loving her the way she loved me. During this first course of therapy, which was twice a week for 3 years, Nancy moved from being completely out of control with her husband and young daughter to being able to manage her intense affective storms and stop abusing both of them. She also successfully worked through her tendency during sex with her husband to have flashbacks of being molested by her stepfather.

As successful as this first therapy was in most respects, Nancy nonetheless left treatment believing that her husband and others were responsible for comforting her when she was upset. Though she no longer smashed things and physically attacked her husband, she expected

him to give her the exaggerated empathy I described in Chapter One, and could not calm down until she received it.

The second client with BPD I will use to illustrate the concepts in this chapter is Rebecca, also introduced in Chapter One. She is the law student who is somewhat prickly when it comes to empathy because she has a dread of intense feeling and vulnerability. She is mostly even-tempered, but sometimes loses control during her sessions and has brief, angry outbursts that rouse her fears of abandonment and/or retaliation by me. In Chapter Five I talked about our collaborative efforts regarding any potential suicidal plans or decompensation, confronting her fears of being controlled and hospitalized. I am using Nancy and Rebecca as case examples both for variety and because the two of them presented with a deep level of affective disturbance, but expressed themselves quite differently.

I attribute the differences in their expressive manner to their environmental influences. Nancy came from a highly dysfunctional and emotional family. Her father left his family when she was six. Her mother screamed and yelled constantly. She and her younger siblings were left to raise themselves as her mother worked in the daytime to support the family, then stayed out at night dating. Later she married the man who would molest Nancy and the next oldest daughter. Nancy's childhood was chaotic in every respect, and there were no consequences for raging, unless it was done in response to the mother, who would rage back with a vengeance and slap Nancy across the face to get her point across.

Rebecca, in stark contrast, came from an upper-middle-class, well-educated family where raising one's voice was considered gauche. Her mother made private angry rants when no one else was around, but traumatized Rebecca and her siblings with her alternating withdrawal and severe criticism and insults. They never knew when they were going to be openly ridiculed and so they tread very softly to avoid inciting their mother. Rebecca's father was the "good parent" who was affectionate, warm, and playful with Rebecca and her sisters. But about a year into her treatment, Rebecca recalled that some of the daily after-school play with her father involved thinly disguised sex play, which involved him having an erection.

Rebecca had occasional intense tantrums as a child and adolescent, but for the most part withdrew to avoid the scathing disapproval of her mother. She presents herself as demure and restrained. But, as I stated in Chapter One, she has only been able to do so through the defensive process of dissociation. To avoid acting on intense feelings, she sim-

ply removes herself whenever any feelings become too strong, be they positive or negative.

Both Nancy and Rebecca presented with significant difficulties in affect management. With Nancy, the affective regulation problem was concerned with finding a way to decrease or eliminate her emotional storms and the distress they caused her and others. With Rebecca, the challenge was to help her to be less withdrawn, to become more verbal, and to have intense feelings in the session without dissociating.

Throughout the remainder of this chapter I discuss our collaborative work, with an emphasis on the emotional life of both these clients and how they fit with the literature on affect and BPD. What follows is a list of some of the salient features of BPD that pertain to affect and the task of affective communication in therapy. These features appear throughout the typical treatment, ebbing and flowing, and are not discrete events. Nonetheless, they can only be discussed one at a time, and I incorporate them into the narratives of both Nancy's and Rebecca's therapeutic relationships with me.

BASIC TRUST AND BEYOND

The analytic literature has favored an emphasis on the work of Bion (2003) and Winnicott (1986) regarding the need for a "holding" environment and providing "containment" for more severely disturbed clients who have difficulty regulating their emotions. It is widely recognized in the therapy literature that clients with BPD and other clients with personality disorders do not typically benefit from interpretation or other strictly cognitive-verbal interventions. So the emphasis for decades has been on containing their intolerable affective states, the general idea being that if the therapist can tolerate the client's intense, unmanageable affects, the client will eventually learn to do the same.

From my earliest days as a therapist I found this strategy to be largely unworkable and ineffective over time. I share my analytic colleague Irwin Hirsch's (2008) concern that too many therapists extend the holding period far beyond its necessity or productivity, for a variety of countertransference-based reasons. Seeing the client as excessively fragile and in need of ongoing, unconditional acceptance does a disservice to her. Once the therapist has established an atmosphere of trust and compassion, it is time to gradually introduce the emotional responses that were lacking in the client's early development. In the spirit of evaluating interventions, therapists treating clients with BPD

need to be aware of the client's need for affective communication and personal feedback. Therapist passivity in the face of constant criticism, emotional storms, or depressive withdrawal and despair is not therapeutic. It may well produce rage, then withdrawal, from the client with BPD who is seeking emotional engagement.

In Rebecca's case, she "tested" me for emotional honesty early in the therapy. In Chapter One I mentioned that she had two previous therapies, both of which were helpful, but mostly in maintaining her rather than facilitating change. The third, and short-lived therapy, was with the young psychiatrist who hospitalized her against her will. Rebecca, as you may recall, said she thought she could work with me because I didn't have the therapist "breathy voice." As she said this, she imitated an excessively soft and disingenuously sympathetic vocal tone. She let me know straight away that she was not interested in being patronized—or hospitalized. What did I think about that?

I freely laughed at her imitation of the "overly solicitous therapist," which she clearly enjoyed. Rebecca has an excellent sense of humor and she was pleased that I could find her jab at my profession amusing. And, as I stated previously, she was very appreciative of my frank conversation with her about the conditions under which I would consider having her hospitalized. At the same time, my acceptance of her first angry outbursts, including her spontaneous slamming of the door as she left her session, helped her to feel safe. Had I reacted angrily or disapprovingly in response to her first forays into showing aggression, I have no doubt that she would have inhibited that behavior, as she had learned to do with both of her parents. They did not allow any anger or rebellion, encouraging her to always be obedient and deferential.

Rebecca also needed me to interfere with her tendency to withdraw and avoid any emotional experience. Her silence placed somewhat of a burden on me, yet if I had not been willing to be more active in the earlier stages of her treatment, I do not think she would have done as well. I gently prodded her to talk more and to specifically talk about anything where she would experience deep feeling. She made it clear to me that she appreciated my efforts. She said she saw herself as living in a shell and longing for someone to break that shell and set her free. (We also addressed the "rescue" aspect of this fantasy, with me noting that I could only invite her to engage with me, I could not make her do so or save her from herself.)

The therapist in training may wonder how to make good decisions about emotional feedback, especially with clients who are both terrified of abandonment and yearning for an emotional response. Recall some

of the principles I laid out earlier. It is vitally important to be aware of the countertransference and use it as a guide to intervening. I think it is natural for most therapists to be compassionate and curious when first treating a client, even if that person is difficult in some way. Like most therapists, I am thrilled to see some new expression of emotion in a client, even if it involves anger toward me. I do not feel resentment or anger at clients like Rebecca who playfully mock mental health professionals or uncharacteristically slam a door.

Quite the contrary, I genuinely enjoyed Rebecca's sense of humor, and was even pleased when she slammed the door because she found the courage to test me. Her subsequent phone messages pleading for my forgiveness told me how frightened she was that I would retaliate. When I assured her I was not angry, she equally assured me that she would not make a habit out of slamming the door and would work to be more aware of her feelings in the session.

The emotions of both client and therapist evolve over time, as the relationship builds and matures. In my earlier description of Dr. S. and his client, they had moved from mutual emotional engagement as she first spoke of her pain to a state of mutual emotional *understimulation* and boredom. Relationships are essentially organic. Changes are inevitable, which means therapists cannot be complacent once a therapeutic alliance has been forged. In the case of Dr. S. and his client, at one point he was deeply empathically involved, but later in the therapy he was anticipating something more. The stimulus value of his client's stories has lessened. The basic laws of mutuality in relationships dictate that his client was probably bored too. It was time for a change.

Regarding Rebecca, though I have not reached that point yet in her treatment, I will no doubt one day be genuinely angry at something she says or does. This has certainly been the case with every other client with BPD I have treated. I think it is important for therapists to expect that their emotional reactions to clients will develop over time and become more complex. Early in therapy, tolerance and safety are key issues. As the relationship develops and the interplay of transference and countertransference deepens, a greater array of emotional responses is not only inevitable but desirable. These responses include negative feelings that may initially stimulate some guilt in the therapist.

Even in psychoanalytic circles the idea of conflict between therapist and client as essential to the process appears to have been largely abandoned (Bird, 1972; Wachtel, 2007). It has been replaced by the ideal of the therapist as all-accepting and capable of tolerating any and all behaviors by the client. Extrapolating from the work of child analyst

D. W. Winnicott (1963), some clinicians appear to view their clients as screaming babies who need to be comforted rather than as adults who are capable of accepting and using accurate feedback. I agree with Hirsch (2008) that this attitude encourages dependency and may produce nontherapeutic regression.

SHAME

During the first course of Nancy's treatment, when she was in her late 20s, she was not yet ready to give up her symbiotic, infantile attachment to her husband. They married young and found refuge in their merger from the cold and hostile environments in which they grew up. Yet they also enabled each other. As postulated by Wachtel (1993, 2007), they carved out a system of relating based on their early relationships that both gratified and frustrated each of them.

Although I would not deny that he was the object of her repeated physical and verbal abuse, Nancy's husband, like many spouses of BPD personalities, unconsciously received vicarious gratification from her emotional outbursts. Excessively restrained himself, he would provoke her when *he was feeling emotionally overwhelmed*. Nancy would inevitably end her storm with sobbing and an acute sense of shame, humiliation, and submission. *She was the crazy one—not him.* I think this collaborative dynamic between clients with BPD and their partners is often overlooked, in part because the therapist who is being verbally abused identifies with the spouse, projecting an "innocence" that is probably not there. Ultimately, the individual with BPD is punished and pays dearly for her overly aggressive behavior. Some of this retribution is justified, of course, but often it constitutes a repetition of an overly rejecting or abandoning caretaker. In the many instances when a client with BPD has been sexually abused, as was the case for both Nancy and Rebecca, their resulting shameful feelings may motivate them to seek out punishment and rejection.

Nathanson (1994) and Basch (1991) have suggested another reason for shame: clients with BPD feel shame in their pursuit of the satisfying affective responses that were denied them earlier in life. They secretly blame themselves for their ongoing emotional neediness and deprivation, and feel they do not deserve what they need.

One of the tasks of the second period of Nancy's therapy, which occurred when she was in her early 50s, was both her individual change and working to change the relational themes of her marriage.

Nancy pointed out to her husband that he needed her to continue her emotional storms. Nancy told me during the first session of her second therapy that the arguing between her and her husband had become intolerable for both of them as they aged, and that this had to stop. So we worked collaboratively on both helping her to see how she made him responsible for her feelings, and how he colluded with her to produce these unbearable conflicts. Predictably, the more Nancy took responsibility for her own feelings, and was able to manage them, the less shame she felt. Breaking this cycle of repetitive shameful behavior is essential for increasing the self-esteem of clients with BPD.

Rebecca's hidden shame was early sex-play with her father, which she had suppressed for many years. When she remembered it in therapy, she was surprised that she had "forgotten" it for so long, but was deeply ashamed when she recounted it to me. Both she and Nancy wondered why they had not stopped the inappropriate sexual behavior by their caretakers, and felt shame about this. Rebecca gradually became aware of her seductiveness with men, of which she had previously been totally oblivious. I believe that she was able to observe herself after much discussion about her experiences with her father. This included the obvious truth that it is never the child's fault when sexual contact occurs between parent and child. I was quite impressed when she became aware of her ongoing seductive behavior and the sense of power it gave her, without any prompting or interpretation by me of any kind.

PSEUDO-AFFECT

It is not unusual for clients with BPD to talk about something that upsets them, especially from the past, and show emotion that seems inauthentic. I have heard many clinicians refer to this as a sign of the manipulativeness of clients with BPD. I agree that if the client cries, and the therapist feels nothing, there is probably something inauthentic about her emotional display. But I actually asked the client with BPD I introduced in Chapter Two, Andrea, about this issue. She is the person who could not sustain a relationship and often had screaming matches with strangers on the street. Andrea was also the person who used the education I gave her about her affective problems with great success.

One night she called my office and left a message. Crying copiously, she was obviously very hurt because her current boyfriend had

ended their relationship. When I returned her call and talked to her in the moment, I could feel her pain and felt quite bad for her. Two days later, when she talked about the boyfriend again, she cried weakly and I felt nothing. I decided our relationship was strong enough for me to take the risk of telling her this and contrasting it with what I had felt when we spoke on the phone. I added that the feelings she showed on the phone seemed strong and genuine, whereas her reliving of the event in her session seemed to be a performance of those emotions. What did she think about this? Was my perception accurate that she was not feeling that much in the moment? (I want to emphasize that this question was asked out of genuine curiosity, was not meant or taken as a criticism, and was stated matter-of-factly.)

Andrea thought for a moment, then said she had to agree that she was not feeling very much. Rather, she wanted to talk about the breakup without making herself too vulnerable. Yet she wanted me to realize she was in pain. I have to honestly say that this understanding between us did not result in any significant change in Andrea's behavior. She didn't want to make herself that vulnerable to me, in part because our relationship would end one day. But it made it much easier for me to deal with her once I understood that her feelings were real, but not being adequately felt and expressed in the moment. She was not trying to manipulate me or deceive me. She was just trying to protect herself.

A related affective issue is detailed by Green (2000), where he describes the fears of the client with BPD of being uncontrollably flooded with feeling and essentially retraumatized in that experience. From my own experience, I agree with Green, but want to add that I think the fear of feeling can be broader in scope. I think clients with BPD, by their own current definition, were not responded to adequately as children. As a result, they felt terribly frightened and out of control, even when they weren't being traumatized. Part of these out-of-control feelings are related to the real helplessness of childhood. They could not control the events of their lives and the emotional impact of those events. These fearful childhood states carry over into adulthood. I find that even the most intelligent and forceful clients with BPD tend to view themselves as having little or no control over their lives.

POWER AND HELPLESSNESS

Feeling powerless, in fact, is a consistent theme in the lives of clients with BPD, and contributes to their companion fears of abandonment,

rejection, and humiliation. Convinced that they are meaningless and have no real impact on others, they are prone to exaggerating their affect and/or giving up in despair. They are typically unaware that others respond with fear, then defensive anger, when they are inappropriately aggressive. There is a disconnect between what they have to know, at least unconsciously, about the feelings on other people's faces, and what they report. From my experience, if you ask clients with BPD what impact they have on others, they will say, "Little or none. No one cares."

My explanation for this disparity between the reality of the impact of the client with BPD and her assessment of herself lies in the power of the affect program laid down in her brain early in life. The client with BPD *expects* to be helpless. When she is confronted with a situation that stimulates her many fears or frustrations, her affect program from childhood is activated, is overwhelming, and overrides the reality of her actual impact. That is why emotional reeducation is so vital to any real change in the internal emotional life of the client with BPD and her relationships with others.

Wanting recognition and love leads clients with BPD to fluctuate, often wildly, between submissive and aggressive behaviors (Linehan, 1993; Russell et al., 2007). The same person who can be routinely verbally abusive may also be routinely obsequious. Yet both behaviors fail to meet the need for love and approval, and ultimately leave the client with BPD feeling secretly ashamed and humiliated. This cycle is endlessly repeated.

Dunn (1994) has pointed out that one of the outcomes of normal emotional development is "the development of *intimacy and power in close relationships*" (p. 355). Lacking this sense of power, clients with BPD clamor for power in their relationships, creating unnecessary power struggles. With some clients with BPD it may seem that *everything* turns into a power struggle and potential impasse. Therefore, it is incumbent upon the therapist to do everything possible to avoid these struggles. This position requires compassion and flexibility—especially a willingness to admit therapist errors or insensitivities. But masochistic submission by the therapist, which I will discuss in more detail later, only fuels a power imbalance in the relationship. Granted, there can be a fine line between letting something go versus pacifying. Achieving this delicate balance stands as one of the goals in treating clients with BPD. Falling short, of course, is inevitable. And, as I stated earlier in this volume, errors can be used instructively by the therapist to get back on track.

THE SUPERIOR AFFECT-READING ABILITIES OF CLIENTS WITH BPD

Unquestionably, the task facing the therapist of a client with BPD is monumental. Usually over the course of many years of treatment, the therapist must help the client with BPD to stop her emotional moving train. Countertransference-based responses, based on fear or suppressed rage, lead mostly to therapist acting out instead of meaningful dialogue. It is not unusual for the therapist to become defensive because she has been "caught" by the hypervigilant client with BPD in a moment of withdrawal or rejection.

Therapists will often say that their clients with BPD seem to have an uncanny ability to know when they are even the slightest bit less available. The therapist's personal problems, fatigue, preoccupations, and negative feelings toward the client are typically picked up almost immediately. Again, the affect research has confirmed what experienced clinicians have long suspected: clients with BPD actually read other people's affect more quickly and more accurately than groups of normal controls (Wagner & Linehan, 1999; Lynch et al., 2006). They also take longer to return to baseline.

The Lynch et al. study was groundbreaking in that it used computerized "morphing" technology in which faces change gradually from one emotional expression to another. Subjects with BPD consistently identified the emerging affective expressions before normal controls did. And they predictably responded more intensely to those facial expressions. The only error that clients with BPD consistently made is that they were more likely than controls to identify a neutral expression as angry or threatening in some way. Not surprisingly, this confirms that their default position is "When in doubt, assume the worst."

MANAGING AFFECT STORMS

The superior ability of clients with BPD to read their therapists' affects, combined with their hyperresponsiveness, expectations of rejection, and inclinations toward aggressive behavior, have earned them the reputation of being difficult to treat. Returning to the discussion of Nancy, I must note that during both of her periods of treatment she presented regularly with affective storms. As a young therapist I was overwhelmed by her intensity and literally had no idea how to handle the situation. Nancy would rail about some perceived injustice, both inside

and outside of the therapy relationship, then sob and rage uncontrollably. Any attempt on my part to intervene was rejected out of hand. Like many new therapists, after she had expressed herself, I would attempt to intervene therapeutically. To my chagrin and frustration, there were too many times when nothing I did was right.

Kernberg (2003) has written compellingly about affect storms in BPD personality and depicts the frustrating scenario in treatment:

> The explosive behavior of some severely ill patients takes the form of repetitive, consistent enactment of affect outburst. Here the patient's verbal communications, session after session, are punctuated by intense affects that momentarily dominate the picture, only to shift rapidly into a different kind of affective explosion. Under these circumstances, a chronically chaotic situation is enacted that may convey the impression that the patient experiences the therapist's every statement as traumatic; the patient's readiness to feel traumatized is consistently, monotonously enacted, session after session. (p. 518)

Kernberg also describes the potentially stupefying lack of affect that is the opposite of emotional storms. In this scenario he notes that the therapist can become overwhelmingly bored, angry, and/or despairing. I would add frustrated. Clearly, Rebecca falls into this latter category.

I admire Kernberg's longtime body of work on BPD personality, and agree with his advice regarding the critical function of limit setting and the importance of maintaining boundaries with clients with BPD. I also agree when he says the therapist must usually wait for the affect storm to subside before he can intervene effectively. And he must do so with "affective engagement"—a term Kernberg does not define. Rather, he simply says that nothing will enrage a client with BPD more than a passive, wooden therapist. Over the years Kernberg has given several examples where he lost his temper with clients with BPD and it had a salutary effect. In spite of this, he does not endorse affective self-disclosure from the therapist, and concludes that treating clients with BPD is complicated.

This is where we disagree. In my opinion, Kernberg's expressions of frustration and anger at his clients with BPD are exactly what they are wanting and needing at the time he expresses his feelings. I have stated previously (Maroda, 1991, 1998a, 1999) that clients with BPD will keep upping the ante until they provoke emotional responses from their therapists—especially anger. They are looking for the therapist to complete the cycle of affective communication by giving them a pre-

dictable, sane, and honest emotional response. The repeated stimulation of this feeling in the therapist, which the client usually reports as occurring outside the therapy as well, clues the therapist that it is time to act.

As I said in the previous chapter, it is this affective exchange that both validates and "contains" the client's intense feelings. Therapist passivity, often defended as being the appropriate way to contain the client's affective storms, is perceived by clients with BPD as withdrawal and abandonment.

My very first private client was a brilliant woman with BPD. She was 12 years my senior, and made mincemeat out of me for at least the first 2 years of therapy. But she was also the person who told me that my words fell on deaf ears. She used to mockingly say things like, "I can't hear you. All I hear is this annoying buzzing in the room, like a fly. It makes me want to swat it. If you have something to say to me, say it with some feeling and power." I never forgot that lesson, and realized that she was accurately describing the impact, or lack thereof, I was having on her. As I became more confident and expressive, she got better. Certainly both client and therapist need to feel safe enough to have this type of affective exchange. Establishing a solid relationship precedes this type of interaction.

TREATMENT AND CLIENT EDUCATION

Those who write on BPD emphasize the vital importance of maintaining appropriate boundaries with those clients. I find it interesting that virtually every experienced clinician knows this, yet clients with BPD routinely convince their therapists to bend the rules in ways that are distinctly nontherapeutic. Graybar and Boutilier (2002) point out:

> In fact, Kroll (1996) noted (and embarrassingly we have experienced) that difficulties in the treatment of Borderline Personality Disorder generally occur when regularly observed principles of psychotherapy are stretched, ignored, forgotten, or discarded. (p. 160)

These authors are not alone in their embarrassment. What needs to be asked is: What is happening between therapist and client that so often results in therapists acting against their better judgment? Why is it so difficult to maintain boundaries with clients with BPD? How can we do better?

I think we have to recognize that there are multiple and intersect-

ing causes for the breakdown of the therapeutic relationship. First, therapists who feel guilty about their countertransference anger or despair are more likely to indulge a demanding patient with BPD. Gabbard and Wilkinson (1994) noted this phenomenon, saying:

> At the very moment the therapist is wishing the patient would disappear, the patient may accuse the therapist of not caring and disliking the patient. Such accusations may create feelings in therapists that they have been "found out." Under such conditions therapists may reproach themselves for their lack of professionalism and attempt to make amends to their patient by professing undying devotion. (p. 5)

They emphasize how important it is to bear the experience of being hated, and also to tolerate hating the client. It was my clients with BPD who taught me to both tolerate and sometimes express my negative feelings toward them (Maroda, 1991).

I think that Gabbard and Wilkinson are right about therapist guilt being a pivotal factor in the boundary crossings and violations that are so commonplace in the treatment of clients with BPD. From my experience, the out-of-control, overly aggressive client with BPD quickly makes the therapist uncomfortably familiar with her own capacities for anger, hatred, hopelessness, despair, sadism, and masochism. The acceptance of negative feelings is an essential aspect of the treatment that must be mutual. A guilt-ridden therapist can not facilitate self-awareness and self-acceptance in his clients.

Clients with BPD fear not just rejection, but emotional annihilation. During intense affective, often unconscious, and body-to-body communications, the therapist may well begin to fear annihilation as well. Viewing this shared emotional experience as part of the natural emotional contagion factor helps relieve the therapist of blaming herself, or her patient with BPD, for this disturbing state of affairs. Becoming comfortable with emotional chaos and a torrent of negative emotions is an ideal we all will necessarily fail to achieve. But a good enough effort depends on a high level of self-acceptance and affect tolerance. Therapist guilt is ideally reserved for actual therapeutic errors, not feelings.

Second, in addition to therapist guilt, therapist anger is rarely expressed constructively. Rather, therapists tend to act out by either aggressively interpreting the client's motivations, being late, rescheduling unnecessarily, falling into silent withdrawal (abandonment), or any number of other passive–aggressive behaviors (Langs, 1974). I will address this issue more in the next chapter, but suffice it to say that most therapists need to do a better job with managing their anger. Keeping in

mind that clients with BPD are exceptionally good at reading emotions, it is rather pointless for any therapist to deny his anger. Doing so challenges the client's reality testing and forecloses the open expression of emotion that the client so desperately needs. Therapist acting out only intensifies the client's rage at being treated unfairly and feeling undeserving of others' respect and responsiveness.

Third, because therapists are conflict-avoidant, they easily fall into pacifying their demanding clients. One of the functions of emotion is to influence others. In the absence of the therapist's honest emotional response, the client gradually begins to dominate the emotional landscape of the relationship. Little by little, instead of the client changing, the therapist changes. He goes against what he knows he should be doing, in part because he is being emotionally overwhelmed and dominated. Falling into masochistic submission, he finds himself giving in to his client with BPD on a regular basis. These submissions may include insincere apologies, questionable fee reductions, failure to charge for last-minute cancellations or no-shows, extended or additional sessions, disclosure of very personal information, physical contact, and even sex. The therapist may scratch his head wondering why he did these things. Unfortunately, no amount of intellectual understanding alone will alter this situation. The therapist has to become a real person, with a real emotional presence in the room. (Self-disclosure is done within the guidelines provided in Chapter Five.) The therapist's affective response to the client with BPD completes the cycle of affective communication and provides needed emotion regulation that failed to develop earlier in life.

Fourth, client education can help prevent breakdowns in the therapeutic process. Successful treatments result from a true collaboration between therapist and client on every level. As I illustrated previously with Andrea, clients with BPD often ask about why they behave the way they do. She was fascinated when I explained the concept of affect programs to her. When I told her she had this reservoir of rage, waiting to be stimulated, she felt understood, not criticized. And she is not alone in her desire for self-understanding. Clients with BPD frequently ask how the treatment will help them. Even if only unconsciously, they do want to understand and gain control of themselves. As Nathanson (1994) said, "BPD clients are grateful for any instruction or treatment that provides identification of and modulation for intense negative affects" (p. 804).

Kraft-Goin (2001) emphasized the importance of a clear framework for therapy, established at the beginning. This includes the roles

of client and therapist, the time and place of sessions, treatment goals, collection of fees, handling of emergencies, and so on. Some therapists write this all out in a contract and have their clients sign it, which is not a bad idea. I have not done this, but often wish I had. The reader may recall the case of Susan, a client with BPD who said she could afford to come multiple times per week, then demanded a fee reduction because she was running out of money.

McWilliams (2004) has written about the value of client education. I have found that informing my clients with BPD of my phone policy early in the treatment has been beneficial. Clients with BPD tend to suffer at separations, especially during weekends and vacations. Earlier I discussed my telephone policies, which I am quick to discuss with my clients with BPD, in particular. In addition to the limitations I talked about earlier, I also emphasize that I am not in "therapist mode" after-hours and on the weekends. What is special about their session times is that for those 50 minutes we are there together, face-to-face, focusing exclusively on helping them with their problems. After-hours phone calls are usually a disappointment, especially to the client with BPD who is quick to pick up any emotional unavailability on the therapist's part. The client may then complain that the therapist is not really "present" and therefore "doesn't care." The outcome may be an extended phone call, fueled by therapist guilt over not wanting to talk on the phone in the first place.

Clients with BPD need to be handled with infinite patience when it comes to understanding and accepting their outsize fears and rage. But they also need someone who is clearly in charge of therapy and knows what to do. Since clients with BPD equally fear intimacy and abandonment, new therapists can quickly become confused when a great session is followed by one where the client is aggressive and critical. Likewise, a terrible session where the client tells the therapist that he is incompetent and making the client worse may be followed by another session in which the client reports feeling better and is highly cooperative. One day the therapist is great, the next he is beyond disappointing. Although it is not easy, effective treatment requires the therapist to ride this emotional roller coaster without falling off.

SUICIDE

An issue related strongly to shame, anger, and affect management is self-harm and suicide. Self-harm, as in Rebecca's longtime habit of

cutting herself, is well known to be a method for affect regulation in clients with BPD. Actual suicide attempts also occur with alarming frequency. Jamison (1999) reports that "nearly three-quarters of those with borderline personality disorder attempt suicide at least once, and 5 to 10 percent do kill themselves" (p. 123). How do these facts affect the therapeutic relationship and how can therapists deal more effectively with these realities? Gabbard (1994) notes how therapists tend to placate their clients with BPD, especially when they threaten to harm themselves.

Throughout this chapter I have emphasized how important it is for therapists to be actively present and emotionally honest in dealing with all clients, but especially those with BPD. The therapist who placates a client who threatens suicide has joined the client in feeling frightened and out of control. What angry clients threatening to hurt themselves need is an intervention by the therapist aimed at facilitating affect management. Especially for clients who suddenly become suicidal in the course of treatment, every therapist needs to ask herself, "Why now? Is this client angry with me for some reason and wants to express this anger through hurting herself?" Maltsberger (1974) documented that countertransference hate was prominent in cases where clients actually killed themselves. As painful as this topic may be for therapists, in many, but not all, cases the communication between client and therapist has broken down when suicide has been threatened or enacted. (This stands in contrast to superficial acts of self-harm that may be used routinely by some clients whenever their defenses are overwhelmed. These have the potential for being stimulated by therapeutic misalliance, but are not always the result of a problem in the therapy relationship.)

Fromm-Reichmann (1959) presented one of the earliest discussions of suicidal behavior as it relates to the therapy relationship. She said:

> In our experience suicide during therapy frequently occurs under the following conditions: The patient establishes his characteristic dependency relationship and enters into his characteristic fantasies of gratification. He then experiences something in the relationship which he interprets as a rejection. Following this, he becomes hopeless about achieving his goal, and then he becomes suicidal. (p. 264)

Fromm-Reichmann does not use the word "anger," but from my experience the client who experiences deep frustration or rejection is not only feeling hopeless and powerless, but also enraged. These exaggerated feelings often result from the aforementioned passivity, overin-

dulgence, and resulting nontherapeutic regression in clients with BPD. The client who threatens suicide feels powerless to have an impact on someone important in her life, and at times that person is the therapist.

When a client is threatening to hurt herself I always encourage her to express any frustration or anger. Often the response will be "I am angry at everyone." That allows me to say something like, "Everyone? That would appear to include me. Can you think of any reason why you would be upset with me right now?" If the therapist knows something went awry in the previous session or during a phone call, it is best not to play the "cat and mouse" game of asking the client a question whose answer you already know. Doing so will only increase the client's frustration and anger.

If you do not know what is upsetting the client, then an honest question and invitation to explore the issue will usually be accepted. Sometimes the client is feeling so out of control, the therapist must first ask her to breathe deeply and take a moment to compose herself so that a conversation about what is bothering her can take place. Again, if this is done in a matter-of-fact way and is not perceived by the client as a patronizing attempt to take her feelings away, it is likely to be welcomed.

At these critical points when the client feels out of control, it is the therapist's job to keep things in perspective and go about the business of exploring what the client is feeling, and being willing to quickly admit to any flaws, weaknesses, or mistakes. I keep in mind that any threat or intense emotional reaction from a client is an attempt to get a response from me that she needs. Even though the client with BPD may not be consciously aware of what is upsetting her, and may give global, diffuse answers to questions about what is wrong, therapists need to keep in mind that some communication from the therapist is needed. The client with BPD is not operating outside of the therapy relationship. She is just not good at being self-aware and expressive about specific emotional events. These problems with expressing emotion constructively lead to suicidal threats as a way of letting the therapist, or some other significant person, know just how distressed she is.

Jamison (1999) reports an interesting fact about suicide in clients with BPD. She says:

> Suicide itself often takes place in the physical presence of another person. In one study, more than 40 percent of suicides committed by borderline patients were witnessed by other people; in individuals with other diagnoses, only about 15 percent were witnessed. (p. 123)

This statistic suggests that, at least for the client with BPD, suicidal actions are a form of communication that requires receipt in order to be validated. Even in actual death, clients with BPD often need to know that someone is aware of their pain. The therapist who panics and immediately brings up hospitalization is likely to get a very negative response. The client may feel that she has become "too much trouble" and is being abandoned by a therapist who no longer knows what to do. Therapists naturally feel upset when a client brings up suicide, but it is vitally important for us to regulate our own affect and be capable of providing both the emotional availability and structure the client is needing.

In summary, therapists who maintain good boundaries; avoid indulgences and other acts that promote unrealistic rescue fantasies and ultimate disappointment; are quick to own up to mistakes or emotional unavailability; and calmly explore the feelings of hopelessness and subsequent rage of the BPD client can be more affective in preventing suicide or other acts of self-harm.

GRIEVING AND AFFECT MANAGEMENT

If there is a short-cut to the end point of insight, self-acceptance, and affect management, I do not know it. From my experience, significant change happens only after years of working hard, day in and day out, with clients with BPD. Our goals are to work hard at understanding them, to set reasonable goals for the treatment, to bear the blows of their insults and criticism, to be willing to feel their pain, and, most importantly, to sit quietly with them while they grieve. When they ask me how they will ever get over their sense of loss and longing for the good mother, I simply tell them they never will. But if they grieve that loss, accepting that they are no longer children and, by definition, can never go back and be mothered as they wished to be, they can have better lives.

Nancy, who was so emotionally out of control for so long, believed unconsciously that if she made enough noise, protested enough, she would finally get what she thought she desperately needed to survive. When she and I reached a point in her second treatment where we discussed this belief, she still insisted that her life would be over if she gave up on finding the perfect mother. Keep in mind that she was now 50 years old. One of the tasks of doing therapy with clients with BPD is gently helping them to see the connections between their behaviors and

events, and the inconsistencies between what they believe and what is actually true.

In this case, I told Nancy that I found her conclusion curious. How could it possibly be true that she could not survive if she gave up on finding the perfect mother when, in fact, she had a good marriage that had miraculously survived decades of emotional storms? She also had achieved the goal of her first treatment, which was gaining enough control so that she would not verbally or physically abuse her daughter, as she had been abused. (Her daughter was working in her profession, had married and given birth to her first child, and had a close, loving relationship with Nancy.) Finally, I pointed out that although she did not have as many friends as she would have liked, she went back to school after her first treatment concluded, finished her degree, and had a very successful career. All in all, Nancy had a good life—especially for someone who was neglected, abused, and given almost no parental guidance and support. I thought that not only had she not perished, she had managed to transcend her impoverished childhood, finding a way to love and be loved by her family. And she herself was a good mother. Did she see the discrepancy between the reality of her life and what she feared?

Nancy was taken aback, but pleasantly so. She said, "Oh my God, you're right. I've thought this way for so long, I just assumed it was true." She also pointed out that it would take some time for her to integrate this new way of viewing her life. But after that day, she began grieving with a vengeance. She cried and cried, session after session. Sometimes she cried out of frustration and rage at the indignities she had suffered; other times, she cried out of feeling hopeless and worthless. Eventually, she cried because she simply felt overcome with sadness.

During both courses of therapy, Nancy would occasionally start rocking and sobbing uncontrollably. Sometimes she would start hyperventilating. Then she would get scared, even panicky. Working from the position of facilitating affect regulation, I would then start talking quietly, telling Nancy she was a bit overwhelmed, and encouraging her to take deep breaths and try to stop crying so that she could breathe better. She always appreciated this intervention and knew I was not rejecting her feelings. Instead, I was helping her learn how to get back in control. Eventually she could do this herself and began to lose her fear of being overwhelmed or destroyed by the intensity of her experience.

In contrast, when she spent too much time at the surface, relating every detail of her day, I would encourage her to stop and move into

something where she would experience some emotion. A fatigued therapist can fall into accepting a client's avoidance of important issues, or even her silent withdrawal. But the client will inevitably begin the next session with complaints or complementary withdrawal. I have been told many times by my clients with BPD that I let them off the hook too easily in the previous session. They will also freely say that the sessions where they cry are the best ones. As Krystal (1988) remarks:

> Grieving enables one to accept loss and to diminish grandiose views of oneself; it becomes the guardian of reality testing, which would have to be sacrificed if painful self-awareness could not be accepted. (p. 63)

He goes on to say that he believes there is an inverse relationship between grieving and becoming depressively stuck. More often than we might like to believe, there is nothing more for clients to do in response to the internal and external crises, as well as the endless disappointments in their lives, than to cry.

METAPHOR AND THE BRAIN

Gregory and Remen (2008) cite Bucci (2002) while discussing the challenges and necessities of helping clients with BPD translate as much of their experience as possible from presymbolic to symbolic experience. They note that in spite of the frequency with which clients with BPD may be facile with language and enjoy poetry and art, they struggle to identify and label their own experience. When clients with BPD are experiencing a free flow of emotion, that is, neither the excess of the emotional storm, nor the emotional insufficiencies of depressed withdrawal or dissociation, they can be helped to understand the links between their thoughts and feelings, and between their behavior and its consequences.

Metaphor has long been valued in the psychoanalytic world for its value in facilitating understanding (Arlow, 1979; Borbely, 1998; Levin, 1997; Modell, 1997; Ogden, 1997). Borbely, discussing the work of Glucksberg and Kayser (1993), notes that metaphor allows us to "capture" the new and connect it to the old. Metaphor is about making cognitive connections, establishing meaning, and creating new cognitive and emotional pathways. Rasmussen and Angus (1996) demonstrated in their research that both clients with BPD and those without benefited

greatly from the use of metaphor, particularly if it was creative and avoided hackneyed expressions with little stimulus value.

Nancy, for example, consistently underestimates her emotional impact on others, as do most clients with BPD. I tell her that, as a result, her behavior is often far more aggressive than is necessary. I told her it's like using a bazooka to kill a fly, which she found mildy amusing and accurate. Using humor not only gets the point across, and hits home immediately, but it helps make the experience more playful, more relational, and less threatening.

Another metaphor I used effectively with her came to mind as I was literally getting dizzy following her when she spoke. She moved her head, body, and arms so much during the session I became disoriented and had difficulty staying focused on what she was saying. I tried to think of a way of commenting on her use of her body that would not be insulting, and would provide her with feedback that would be helpful.

I decided to ask if she was aware that she moved around a great deal when talking, and that she reminded me of a prize-fighter, ducking and weaving, in perpetual motion. Was it perhaps, like the fighter, to avoid being hit? She responded immediately with curiosity and the confirming response that she had noticed others having difficulty maintaining eye contact with her, but did not realize why. She especially liked the notion of not being able to hit a moving target. I told her it would be much easier for me to listen and make contact with her if she could possibly remain more still. She agreed to work on it and noticed a difference with me and with others outside of therapy when she reduced her physical movements.

In Chapter Five I illustrated the power of metaphor and humor when I responded to Jennifer's request for feedback by comparing her to the characters in the television series *Third Rock from the Sun.* This metaphor captured much of her experience, yet also allowed room for creative play. She told me that she continued to turn this comparison around in her mind for weeks, finding new insights, and humor, as she did so.

Once again, neuroscience is helping confirm the therapeutic value of interventions like promoting the use of metaphor. In *Coming into Mind* Wilkinson (2006) notes the neuroscience research on metaphor:

> In particular we might note Levin and Modell's work that shows more brain centers light up in response to metaphor than any other form of human communication, thus indicating the formation of new

> neural pathways arising from and in response to the symbolic (Levin 1997 and Modell 1997, cited in Pally 2000: 132). (pp. 9–10)

All clients use this process, of course, and it can be safely described as an essential aspect of the therapeutic action of psychodynamic treatment. Clients with BPD, however, can have more difficulty with this process and may need more assistance and a longer treatment period to capably use metaphor on their own.

It is well established that patients with BPD have insecure attachments, which helped produce and continue to feed their annihilation anxiety and fears of abandonment. Wilkinson (2006) also addresses this issue, noting that the establishment of a secure therapeutic relationship, where the use of metaphor and other emotional–cognitive linking is ongoing, may actually change the client's attachment pattern. She says:

> Affective neuroscience is encouraging in that the emphasis on plasticity, with its possibility of the remaking of mind, means that the empathetic analyst may be experienced in a new way, leading to change in the very nature of basic attachment, meriting a new category of attachment, that of "learned secure." (p. 182)

SUMMARY

The presence of both early trauma and hyperemotionality in certain clients, particularly those with BPD, has left clinicians feeling frustrated and helpless far too often. This chapter emphasizes the need for expressed emotion, in both therapist and client, as well as patient education. The client with BPD is the centerpiece of this chapter because of the unique challenges he or she presents in therapy. A therapist who can master the techniques involved in successfully treating clients with BPD is likely to do well with affect management in less challenging clients.

Rather than seeing emotional clients as manipulative, destructive, and out to ruin the treatment, even though these things will no doubt be true at times, therapists can benefit more from viewing the client with BPD as affectively overwhelmed, out of control, likely to possess certain cognitive deficits, lacking insight about her situation, and desperately in need of affective responses from her therapist. These affective responses begin with empathy and patience, but evolve over time, in accordance with the client's needs. Confrontation, client educa-

tion about both their individual problems and the therapeutic process, behavioral feedback, aid in developing the capacity for self-soothing, and other affect management techniques are all interactive strategies that therapists can use effectively. Completing the cycle of affective communication, often lacking in their early attachment experiences, is vital to their development of affect regulation. Seeing suicidal threats as expressions of suppressed rage that need to be expressed, and often involve the therapist, can help avoid incidents of self-harm.

Responding with emotional honesty to the client's need completes the cycle of affective communication, providing missing components in the client's early attachment experiences. Clients with BPD often believe they will only be helped if they get what was denied to them in their childhood. In the sense of honest, affective responding and feedback, they are correct. This affective reeducation is a constructive alternative to the client's pleas for the love and special attention she feels were lacking in her childhood. Over time, these new emotional experiences create new neural pathways, producing permanent change.

Finally, therapist-facilitated understanding of clients' thoughts and feelings, along with the use of metaphor, can help them to go from disorganized to more organized personalities. Linking thoughts and feelings to each and to behavior helps the client to achieve newfound integration. Schore (1994), LeDoux (1994), and others have emphasized recently that neuroscience research confirms the plasticity of the brain well into maturity. Change becomes more difficult as we age, but is still possible.

I have been inspired by my client Nancy's ability to establish the capacity for self-observation, and to change unwanted behaviors, during a course of treatment while she was in her 50s. Attachment theory and research also confirm conventional wisdom that clients who form and maintain relationships over time can do the same in therapy and have a good outcome. Therapists who understand what their clients actually need, and who are willing to make themselves vulnerable, can facilitate change in even the most disturbed clients.

8

Confrontation and Countertransference Anger

Overcoming the Therapist's Aversion to Conflict

> According to my informal observations, most people who are attracted to being psychotherapists like closeness, dislike separation, fear rejection, and suffer guilt readily. They tend to be self-critical, to be overly responsible, and to put other people's needs before their own.
>
> —Nancy McWilliams (2004, p. 105)

All therapists are naturally limited by their own personal view of the world. Most could benefit by looking harder at why they became therapists and what types of affirmation and gratification they are seeking from their work (Maroda, 1991, 2002; Sussman, 2008). From my experience working with therapists, many suffer from being too passive, masochistic, and conflict-avoidant. Often motivated by the need to heal a depressed or otherwise emotionally disturbed family member, therapists gravitate toward soothing and peacemaking behaviors. Having inhabited this role as children when they were powerless to change their parents' behaviors or attitudes, their single-minded empathic devotion was adaptive. They were not in a position to confront their parents and naturally wanted any parental conflict to end as soon as possible.

This adaptation can be any therapist's greatest strength and greatest weakness. Focusing on empathy and understanding is a natural

and essential starting point for any therapist. Clients who are suffering frequently blame themselves for their pain. They feel tremendous relief and gratitude when they are listened to and accepted. So, in the early stages of therapy, the role of the therapist as sensitive, empathic responder is highly effective.

But a wide array of other attitudes and interventions are therapeutic yet may not be part of the repertoire that many therapists established in their childhood training as caretakers. These behaviors can include asking penetrating questions (children do not probe their parents' thoughts), confronting (children are not in a position to confront their parents), expressing frustration or anger (this runs counter to the child's goal of making peace), and setting effective limits (children do not set limits on their parents' inappropriate behaviors). Not all therapists have difficulties with any or all of these behaviors, and some therapists certainly err in employing them too much. But, generally speaking, therapists could afford to be significantly more proactive, interactive, and confrontational with their clients.

Even when therapists undergo their own personal treatment, they may still lack the ability to be appropriately assertive with their clients. A therapist's personal treatment often fails to develop his or her capacity for accepting and productively using negative affects, including assertiveness, because the treating therapist did not encourage conflict. Thus, the conflict-avoidant young therapist is likely to be treated by the older conflict-avoidant therapist, which produces yet another generation of therapists who deny their anger and are reluctant to engage in confrontation for fear that it may cause irreparable damage.

My own analyst often played down my anger toward her and others, typically pointing to underlying motivations, such as being hurt or feeling too vulnerable. Depending on the circumstances, this approach can be valuable and vital to self-understanding. But it represents only one aspect of self-awareness, and does not address the need to identify, accept, and make decisions about expressing negative feelings without shame. I'm reminded of many parents who will immediately respond to a very young child's expression of "I hate you!" or "I hate Johnny!" with comments like "No you don't. You shouldn't hate anyone. You're just upset because (fill in the blank)." Less tolerant parents who have their own anger management issues may actually scream at or hit a child who spontaneously proclaims his own anger or hatred. So the therapist's avoidance of conflict or anger is understandable, given that our culture does not endorse the full range of human emotions, let alone provide tools for managing them.

When I was a young therapist, I was taught to wait patiently for the client to gain insight on his own. I was told that my job was to listen and interpret. To confront the client was directive, prescriptive, nonanalytic, and potentially bullying. Think about the television and radio therapists who bash clients for entertainment value. A satiric "What were you thinking?" is self-evidently not therapeutic. Yet these programs are popular, in part because people need to be confronted more than they are in everyday life. The psychoentertainment programs provide momentary relief for those who have failed to confront others' bad behaviors or who need to be confronted about their own. As I stated previously, we live in a conflict-avoidant society where even the most abusive people are rarely directly confronted with their behavior and its effect on others.

Viewing the therapeutic relationship as collaborative, and the client's behaviors as purposeful, creates new avenues for interventions. A client who acts out rather than verbally expressing a conflict is someone who cannot bring himself to see or discuss certain truths. Important topics may never see the light of day if the therapist is not willing to address client behaviors that reveal underlying problems. Therefore a confrontation may be needed as a *starting point* for exploring the underlying feelings and motivations for the client's behavior.

CONFRONTATIONS ABOUT MONEY

For example, many therapists are reluctant to confront clients who do not pay their bills, often waiting until the client has run up thousands of dollars. Even if the therapist is not in need of this money—which is not usually the case—prompt payment is a vital aspect of boundary keeping. My early psychoanalytic supervisors impressed upon me the need to expect timely payment in the interests of maintaining my professional stance in relation to my clients. Failure to collect the fee feeds client feelings of entitlement and rescue fantasies. In addition, I have never had a client who paid late who did not also have problems paying other bills. Deep-seated resentment over having to pay *any debt* characterizes the chronically late-paying client.

Waiting indefinitely for the client to recognize this as a problem strikes me as a waste of valuable time (that the client is paying for) and shirks the responsibility of the therapist to bring issues out in the open. Certainly, any issue that directly affects the therapist, or the boundaries of the therapeutic relationship, rests firmly within the realm of the

therapist's responsibility. A therapist who avoids confrontation about money is evading her responsibility for addressing problematic behaviors in the client's life. She also leaves dormant any fantasies the client may have about being special, being rescued, or expressing anger toward the therapist through late or nonpayment of fees.

Avoiding this unpleasant topic may be particularly tempting if the therapist is being paid a salary at an agency or clinic and the late payment does not affect her own paycheck. Nonetheless, the client's issues with money need to be addressed. Insisting on timely payment and gently encouraging the client to explore his feelings and fantasies about paying are not mutually exclusive. Rather, they are the surface and depth aspects of the same issue.

Financial hardship, of course, is a different matter. If I confront a client who has not paid her bill and discover that she was too embarrassed to tell me that she could not pay due to some unforeseen expense, I discuss a payment plan for catching up. I then encourage the client to bring up any problems with payment in the future rather than waiting for me to do so. One time in my career I actually had to insist on a reduced fee when I realized why one of my clients was always behind. I finally asked her about her annual income and discovered it was impossible for her to pay my full fee—something she was too embarrassed to admit. I told her that it simply was not realistic to think she could devote almost her entire discretionary income for therapy. She would always fall behind when car repairs and other unbudgeted events occurred. She reluctantly agreed to the reduced amount I proposed, based on her income, and she subsequently was able to pay in a timely way.

CONFRONTATIONS REGARDING LATENESS

Clients who are late to their sessions tend to apologize. I naturally accept their apology and move on, particularly if they were caught in a traffic jam or stuck in a meeting at work. Interrogating the frustrated client who has already lost some of her valuable session time certainly is unnecessary and potentially punitive. But what about the client who is chronically late? Should this tardiness be ignored, particularly if the client is profoundly apologetic? I agree with Langs (1973) that it is a mistake to do so. Always bearing in mind that it is not our job to control our clients, I have found that the client who is chronically late to her sessions tends to be late for everything.

Recognizing this as a control issue for that person and gently urging the client to explore the matter may result in a change of behavior over time, but not always. McWilliams (2004) talks about how some patients come late no matter how much you discuss it or interpret it, based on what they can tolerate.

I treated one woman for many years who never ceased to be late for most of her sessions, no matter what I said about it (I found it frustrating) or how much we explored the issue. We would talk about it, she would come on time for a while, then she would slip back into being late again. Interestingly, this same client was also chronically late paying her bill, but did change this behavior when I insisted on it. She soon began paying all her bills on time and was eventually quite proud of the fact that she was out of debt and had a good credit rating. I'm afraid I cannot report any such success with her lateness. The simple truth was that she was motivated to resolve her money issues but not really interested in changing her lack of punctuality.

At one point I had to decide whether or not I could live with her lateness, or if it was something that created too much frustration and anger on my part as I killed time waiting for her to arrive. I decided to continue treating her when my efforts to help her change this behavior failed. But I think therapists must decide these matters for themselves. If I had remained frustrated and angry or detached during her sessions, then it would have been in her best interest for me to say that I could not treat her unless this behavior changed.

CONFRONTATIONS ABOUT APPARENT CONTRADICTIONS

Like all of us, clients inevitably reveal contradictions, either in their value systems, their attitudes, or their behaviors. Gently pointing out these contradictions when the client appears to be unaware of them is part of the therapeutic process. Certainly, this type of confrontation needs to be done in a nonjudgmental, matter-of-fact way, and only after establishing a good working relationship. Later I distinguish between the therapist's passive–aggressive behaviors and constructive confrontations.

I use confrontation when clients discuss issues repeatedly and fail to see their own role or the inherent contradictions in what they are saying. Again, I was taught to wait for the client to achieve awareness of these issues on his own, which may happen. Certainly, some clients

do gain insight quite quickly when they hear themselves talk—they do not need intrusive comments from the therapist. But when a client keeps making the same mistakes over and over again, or keeps saying contradictory things over and over again, then it is time for the therapist to step in and make note of this issue so that a deeper exploration can take place.

A constructive confrontation ideally allows the client to see himself and feel the emotional discomfort of his internal conflicts. He must then maneuver internally to find relief. That may come either from continuing to rationalize his actions or by staying with the discomfort and moving toward change. The therapist cannot dictate the outcome, but can be the catalyst for looking deeper. Masterson and Klein (1989) and others have written extensively about confrontation, particularly as it applies to working with clients with borderline personality disorders. As I stated in the previous chapter, it is virtually impossible to treat a client with BPD successfully without confrontation. But from my experience, every client needs to be confronted at some time or another about a blind spot that persists. What follows are two case examples of confrontation.

The first example comes from the previously mentioned case of Rebecca. In addition to her traumatic childhood and subsequent reliance on withdrawal and dissociation, she had frequently cut herself. She warned me at the beginning of her treatment that she had continued to do superficial cutting throughout her two previous treatments and was likely to do the same with me. However, she was quick to add that she wanted to stop this behavior and we agreed on this as one of our goals. One of the comments that she had repeatedly made from the first day of therapy was that she "wanted to be normal."

The reader may recall that we also had an agreement about phone calls (they would be short and must be requested by phone) and e-mails (I would read what she sent but did not reply. E-mails would be discussed in the next session.)

One Monday, after about a year of therapy, Rebecca came to her session and announced that she had cut herself over the weekend. I expressed concern and asked her to talk about it. I also asked about the severity of the cutting. She showed me her forearms, which had a few superficial, but certainly noticeable, thin cuts on them. When she talked about the various feelings that led up to her cutting, I said I hoped that she might be able to express those feelings in her sessions with me rather than hurting herself. She said she was tired of being so crazy and feeling out of control.

She became a bit self-pitying for a while, which I understood. Finally, she lamented once again, "I just want to be normal." I responded with, "Well, you know normal people don't cut themselves." She seemed a bit surprised that a therapist would talk to her like that. (She was accustomed to oversolicitousness when she cut herself, which I view as potentially reinforcing of any self-destructive behavior.) I quickly added that I knew it wasn't easy to stop a habit she had acquired many years earlier. I also noted that she wouldn't be able to stop cutting herself until she could find another outlet for her self-hatred and despair. But I was convinced that her cutting was something that she could eventually stop doing.

Rebecca seemed to enjoy this conversation and said she would try to get to more feelings in her sessions. She promised that if she felt like cutting herself again, she would work on managing her emotions and soothing herself rather than hurting herself. I said this sounded like a good plan. She did not cut herself for a year. Unfortunately, Rebecca became terribly upset after ending a relationship with a controlling boyfriend, and felt the urge to cut herself again. She left a phone message for me telling me she was going to cut herself, but did not ask for a return call from me. It was difficult for me not to call her, but I managed my anxiety and concern, and kept to our agreement.

When Rebecca arrived for her next session, I was prepared for her to be depressed and to have possibly cut herself. To my surprise and relief, she began the session in an upbeat, talkative mood. I said I was surprised. Then I suddenly realized that she had not cut herself. I looked her in the eye and said (again, matter-of-factly), "Did you cut yourself over the weekend?" She replied, "No, I did not." I said, "That's great. What happened to change your mind?" She threw me an impish look and said mockingly, "*Normal people don't cut themselves*." I laughed and said. "Yes, indeed. Very good."

I want to reiterate several points in regard to confronting clients with contradictions. First, Rebecca had repeatedly brought up the issue of being "normal" and we talked about what that meant. She wanted to be free of her preoccupations with death and suicide; wanted to stop cutting herself; wanted to stop dissociating; wanted to feel more comfortable and to interact more naturally with others; and wanted to fall in love. So my confrontation with her centered on an issue that she had already established as something she wanted to change. My comment "Normal people don't cut themselves" was said without sarcasm or any critical tone. I was simply pointing out the discrepancy between

what Rebecca wanted for herself and how her behavior was incompatible with that goal.

I also want to emphasize that Rebecca and I had established a very strong, positive therapeutic alliance that allowed me to make this intervention without fear of her interpreting it as ridicule. Over time I had seen that she liked it when I confronted her constructively and she had told me from the beginning that she liked the truth and did not want to be coddled or treated like a fragile, crazy person.

CONFRONTING MOLLY

Another example of a difficult and potentially painful confrontation relates to Molly, a client I have not discussed previously. Molly was in her late 20s when she came for therapy. She was terribly depressed and had gained 30 pounds in the previous 6 months. She was approximately 100 pounds overweight and already had high blood pressure at her young age. Molly had struggled with her weight her whole life, and it had gone up and down. Her weight went down when she left for college, escaping her suffocatingly symbiotic parents. But she ended up marrying a man who was just as controlling and exploitive as her parents had been. Having slimmed down in college, she began to put weight on again after her marriage.

Ironically, it was her husband's idea for her to begin therapy because he could not tolerate her uncontrolled crying, occasional bouts of rage, and weight gain. As it turned out, he was completely oblivious to his role in her unhappiness. She was almost equally unaware that she had re-created her relationship with her parents in her marriage. As Wachtel (2007) so aptly describes, Molly chose a man who was like her parents in that he wanted to be taken care of and viewed her as a narcissistic extension of himself. Then she trained him to exploit her endlessly while she martyred herself.

When she began therapy she was working almost 60 hours a week in the family business, while also doing all the grocery shopping, cooking, cleaning, and outdoor maintenance on their house. Her husband was in graduate school and did the laundry. When I asked her if this arrangement seemed fair to her, she said her husband didn't like doing any of the chores so she just automatically did them. She denied feeling any anger toward him, but mentioned that she would keep him up late at night crying and being angry with him for something he had said

that hurt her feelings. This situation represents my first confrontation with Molly.

I said to her, "So you punish him by keeping him up late into the night, with you crying and out of control, when you know how much he hates that?" She looked shocked at first. But she quickly realized that keeping him up or even waking him up was indeed punitive. She thought she just stuffed all her anger down. But when we talked she easily saw how her behavior constituted getting even with her husband. I suggested that perhaps she could focus on the day-to-day things that really bother her and start telling her husband before she becomes so frustrated and out of control.

This confrontation helped Molly to face the discrepancy between her self-perception as a long-suffering good person who wouldn't hurt a fly and her actions. Realizing that she was emotionally torturing her husband when she couldn't take it anymore shattered her unrealistic and unattainable self-image, and motivated her to change her behavior.

Over time, Molly became much more assertive and stopped her evening rants. Instead, she simply told her husband when he was asking too much from her. His favorite phrase was "Can you do me a favor?" Often she was met with this phrase as she came in the door, holding two bags of groceries, after working all day. When she replied, "No, I think that's something you can easily do for yourself. And I am tired," he flew into a rage. He tried to "guilt" her into submission, telling her she didn't love him and was being disrespectful to him. She did not allow him to manipulate her and, not surprisingly, she improved significantly and began losing weight. He, however, became despondent.

He had hounded Molly about having children and said if they just had a baby, everything would be better. They would be a real family. Molly wanted children and became pregnant, still hoping to save the marriage. After the baby was born, her husband refused to change his son's diapers or hold him when he cried. Moreover, as he observed Molly devoting so much time and giving so much love to the baby, he *became vegatatively depressed.* He stopped attending classes and isolated himself.

As much as I believe in the intricate and complex psychodynamics of relationships, I somehow am still amazed when I see dramatic shifts in relationships like the one between Molly and her husband. Some couples have a degree of understanding of how each of them enables

or shores up the other—often at great expense. But Molly's husband could not, *would not,* discuss their relationship, so no progress could be made. He went on antidepressants. He began therapy himself. But nothing helped. His therapist fired him because he was so obviously selfish and lacking in any insight or ability to take responsibility for his behavior. He just wanted everything to go back the way it was, with Molly sacrificing herself to meet his every need. He was jealous of the baby and now wished they had not had a child. Eventually, Molly and her husband divorced, at her instigation.

CONFRONTATION RELATED TO HARMFUL BEHAVIORS

Certainly, therapists want to minimize or eliminate any behaviors that are harmful to the client or to other people in the client's life. Most therapists do not hesitate to express concern when these matters arise. Yet the same conflict-avoidant motivations can come into play, even when the client is hurting himself or others. I remember how difficult it was for me, about 25 years ago, to tell a client that I could not continue treating him if he persisted in his behavior. I will call him Charles. Charles was a 20-something who had just finished his education and was already successful in the business world. Although he was quite intelligent and hard working, everything came easy and quickly to Charles because he was tall, well built, and incredibly handsome. His manner was also seductive. He was very confident of his movie-star looks and the effect he had on both men and women.

Charles came for therapy because he was having recurring symptoms of anxiety and hypochondria. Although his most frequent fear was of contracting AIDS, his hypochondria was not limited to that disease. He regularly saw physicians to get his multiple symptoms checked out. He was repeatedly told that he was not only healthy by most standards, he was incredibly fit and far healthier than his peers. Someone finally suggested that he go for therapy, which he decided to do.

I liked Charles from the minute I met him, and was frankly flabbergasted by how attractive he was. At first it was difficult to focus on the underlying pain that he tended to cover with his jovial and slightly seductive manner. I began to see why everyone simply gave him whatever he wanted. But the next logical question was, How can someone with these gifts, who is happy in his work and his private life (according to his report), be having all this anxiety? Something doesn't fit.

Charles had not yet found a steady partner, but dated frequently and had sex whenever he wanted it. In fact, virtually every time he went out to a bar, women came up to him and gave him their phone numbers. He was offered sex with attractive women every time he went out. His friends were very envious, of course, and teased him. But they gained vicarious gratification from his exploits and were proud to have him as a friend. Charles gradually spoke of being a bit tired of sleeping with so many different women. So I asked him if he always went home with someone. He said, "Yes, of course. I can't turn down sex with an attractive woman." I asked why not. "I don't know. I like sex, so that's one reason. But it would just seem weird to turn it down. Guys don't do that." The more we talked the more evident it became that Charles's good looks were both a blessing and a burden.

I began to wonder about the connection between Charles's fear of contracting AIDS and his need to live up to the macho ideal of never turning down sex. Could it be that he was insecure about his sexuality? Did his fear of AIDS reflect some expectation of punishment for his sexual behavior? I didn't verbalize these thoughts to Charles, but I did ask more about his sexuality. What was your first sexual experience? Was it positive or negative? I was quite taken aback when Charles confessed that his first sexual experience was with his 17-year-old female baby-sitter, who had sex with him when he was 11. I asked him how he felt about this. He said, "Fine. She was pretty and she taught me how to please a woman. Most guys would give their eyeteeth for that experience." When I said it was actually sexual abuse, Charles was taken aback. But he listened and became quiet.

At the next sessions Charles confessed something to me he had never told me, or anyone, before. He had herpes and continued to have sex with women without informing them. I asked if he felt guilty. He answered no. Women who throw themselves at him and go for one-night-stands know they are taking their chances. I suggested that perhaps he had some anger toward women that came, in part, from his premature sexual relationship with his baby-sitter. Was spreading herpes his revenge? Charles denied he was doing anything wrong. He said he at least did not have sex during an outbreak. I pointed out to him that he could spread herpes even when he does not have a visible outbreak.

Charles and I discussed his outlook on casual sex and herpes over the next few sessions. I asked him to think about the consequences of his behavior. He reported his actions honestly to me. I asked if he had thought about telling women that he had herpes before he slept with

them. He replied, "If I do that, no one will have sex with me." I pointed out that since a more serious relationship was part of what he was looking for, and that the casual sex had become boring, maybe he could just taper that off and find someone to date. He said he had thought about that, but he was like a kid in a candy store. It was hard to stop. Finally, I just told Charles that I could not, in good conscience, continue to treat him if he continued to potentially spread herpes. He said he didn't think that was fair. Wasn't I supposed to be neutral? I told him I couldn't be neutral about this matter. For me, it was a moral issue. He said he would think about it.

Charles came back for the next session, grudgingly saying he would not have sex with women anymore without telling them about the herpes. As a result, he had very little sex and finally began dating someone, whom he told about the herpes. I am not naïve enough to think that Charles *never* had sex again without disclosing his condition. But I do believe that it was important for both of us that I confronted him with the consequences of his behavior. The facts that his general anxiety and hypochondriacal fears decreased dramatically also serve to support my intervention.

Without going deeper into Charles's history, I should note that his father was largely absent and his mother worked the second shift, which is why he spent so much time with the baby-sitter. His parents were hard working but had little time for providing guidance and instilling values other than the importance of hard work. Charles was a decent person, hard working, and extremely ambitious. He was determined to get an education, wear nice suits, and obtain the money and power that eluded his parents. His good looks, intelligence, and charm helped him to make his way in the world, but did not build his character or sensitize him to the needs and rights of others. He needed someone to confront him and help him to find an ethical path as he built on his strengths and successes.

Our work together resulted in Charles having less sex, since he was now informing women that he had herpes. He actually became proud of his willingness to be truthful. A few months later he began dating someone regularly, his hypochondriacal fears and general anxiety had abated, and he terminated his therapy. I had every reason to believe that he was pleased that I confronted him. The fact that he remained in therapy and made further progress supported my conviction that confronting him about spreading herpes was the right thing to do—for both of us. Had he refused, the treatment would surely have ended. Either he would have decided to leave because I was asking something from

him that he did not want to give, or I would have had to refer him out because I could not live with witnessing his reckless sexual behavior.

THERAPIST MASOCHISTIC SUBMISSION

When I wrote *Seduction, Surrender, and Transformation* (1999), I elaborated on Emmanuel Ghent's (1990) classic paper which delineates the difference between masochistic submission and surrender. Ghent said emotional surrender was part of a therapeutic giving over to one's own feelings that he saw as an essential part of the process. He thought that many people masochistically submitted rather than truly surrendering. In his article he was talking about the patient, not the therapist. As part of my ongoing attempt to reframe the therapeutic process within the context of mutuality, I applied Ghent's principles to the therapist as well. I said that the therapist had to emotionally surrender to the patient at critical times so that the patient could do the same. Unfortunately, too many therapists masochistically submit rather than risk real vulnerability.

The epigraph from McWilliams that appears on the first page of this chapter says that therapists tend to be self-critical and put others' needs before their own. I disagree with this last point. I think therapists *believe* they are putting others' needs ahead of their own when they are often simply martyring themselves. When I ask people if they feel martyred, they generally seem to identify this state very easily. It feels qualitatively different than a loving and willing sacrifice. When I ask how it feels, the response is inevitably "Bad." Nonetheless, when I point out to therapists I am working with that they appear to be martyring themselves, they are often reluctant to think about changing their behavior. Perhaps this "self-sacrifice," which begins for many therapists early in their childhood, is such an integral part of their identity that changing in this respect would threaten their sense of who they are. For example, when I have pointed out to therapists that they appear to be martyring themselves, even when they agree with this observation, they often immediately rationalize it with a statement like "Well, I know I shouldn't keep letting this patient call me at home, but I think she is getting better and will cut back on this soon. I don't want to do anything that might hurt or alienate her right now." Whether I am talking to a client who martyrs herself or to a therapist who does the same, my advice is to stop and find another way. Martyrdom breeds guilty inequality and seething resentment on both sides.

CONFRONTING CLIENTS WITH WHAT THEY KNOW BUT CANNOT SAY

In the following example, it is the client who is martyring herself because she was trained to do so by her malignantly narcissistic mother. In this example my client told stories about her mother in virtually every session. The empathy I gave her regarding her level of frustration, anger, and fatigue was helpful, but did not result in any change. Change did occur, however, in response to the vignette that follows.

Anne, a nurse and mother of two, came for therapy because she suffered from severe bouts of depression and anxiety. She was quite shy, soft-spoken, and passive—very much a pleaser. She was in her late 40s, her children were adolescents, yet she remained in a pathological dependency relationship with her mother. She readily admitted that she was overly solicitous of her mother and was hurt by her criticism and rebukes. Her mother was extremely needy, calling Anne several times a day, and making unreasonable requests of her time. I asked if her mother was alone. Anne replied, "Oh, no, not at all. She's a widow, but has a large group of friends who play cards regularly and go out to eat. And she belongs to a church group as well." I then asked why she had such difficulty saying no to her mother. Anne answered that her mother became verbally abusive if she refused any of her demands. The more I heard about Anne's mother, the more I thought she was crazy. So I asked Anne how her sisters related to her mother. Anne said they felt sorry for her because she was always so unhappy and needy. They both had distanced themselves from their mother by moving away as far as possible while still remaining in this country, yet they admonished Anne, much as her mother did, for feeling burdened by her or being upset by her biting criticism.

One day Anne was telling me about how her mother had called and asked her to drive her 30 miles to a mall where she liked to shop. (This was about 6 months into the therapy and Anne and I had established a good working relationship.) Anne said she was about to take one of her kids to a soccer game. Moreover, that evening she and her husband had a social engagement. She politely told her mother that she couldn't do it right then, but would take her another time. Her mother immediately berated Anne, telling her she was selfish and uncaring. Since Anne routinely goes out of her way to spend time with her mother and make her happy, she felt totally demoralized by these comments. Her mother's remarks are so nasty and so out of touch with the actual reality of their relationship, Anne is at loss for what to say or do.

As she sat in my office looking like she had the weight of the world on her shoulders, I said, "Has your mother always been this crazy?" Anne burst out laughing and was wide-eyed, as if to say, "Oh my god, you can't say that, can you?" I laughed too, and she told me how guiltily relieved she was by what I had just said. Whenever she asked her sisters if they thought her mother was a bit disturbed, they rejected that notion completely and told Anne she shouldn't have such negative thoughts about their dear mother. Anne secretly knew the truth about her mother's mental state, but had never had that view confirmed by anyone else. After that conversation Anne engaged me in discussing her mother's psychodynamics so that she could understand her better. Over time Anne began to slowly assert herself with her mother and gain some freedom from her tyrannical demands.

HANDLING CLIENT ANGER

When clients become dissatisfied and angry, or when they come to treatment with rage and vengefulness as a treatment issue, many therapists do not know how to handle them and their aggression. Wanting to be seen as good, kind, compassionate people, and perhaps feeling guilty over not being more responsive to their patients, they often masochistically submit during periods of verbal abuse by patients as a substitute for emotional honesty. It is easier to sit quietly and let the angry client rail at them than it is to express hurt, anger, confusion, or whatever else might be stimulated.

But no therapy is taking place when the therapist pacifies or silently withdraws from an angry client. Even worse, the angry therapist who suppresses his feelings is likely to act out in a passive–aggressive manner, canceling or rescheduling the offending patient, or forgetting to announce a vacation. All of us have done these things, of course, but I believe they happen much more frequently when the therapist is denying and suppressing anger or hatred toward the client.

While it is easier and safer to pacify or withdraw, and while these are natural defensive behaviors when attacked, therapists should struggle hard within themselves to get out of the position of masochistic submission. Momentary retreat may be necessary to get your bearings and to think about what is going on and what to do next. But sustained withdrawal, with or without silence, is nontherapeutic.

The client is looking for an affective response and will either be contemptuous of the therapist for retreating or submitting or will be hurt and feel abandoned. I offer here some specific examples of what I have said to clients in similar situations. But these examples are only guidelines. Therapists need to find their own voices within their own personality styles and comfort zones. I am emotional and gregarious, so I will naturally respond differently from someone who is quiet and shy. We can overcome the resistance to developing techniques by emphasizing that they will only work well if they are incorporated into the therapist's own way of speaking and are done with sincerity and conviction.

Many of the technical interventions that I recommend are based on the theory that change only occurs when the client and therapist are experiencing deep emotion. Almost all clients need the therapist to complete the cycle of affective communication that they initiate in the treatment. Most of my interventions are predicated on the notion that it is therapeutic to be emotionally engaged and, at the client's behest or as a path out of impasse, to disclose what we are feeling. A vitally important aspect of setting up guidelines is the recognition that not all therapists respond with the same emotions, or to the same degree, as others. That's where individual judgment and self-assessment merge with technical guidelines to decide how and when to intervene.

Returning to the example of dealing with an abusive client, most people respond with anger when they are abused. Others are merely annoyed. Still others are more hurt than angry, or even fearful. And some therapists maintain themselves by not letting anyone get to them. These therapists are more likely to be unaware of any strong emotions until they blow up and create an enactment. So now things are getting more complicated.

The therapist who is reacting emotionally first needs to identify what he or she is primarily feeling toward the client. She also needs to decide what behaviors of the client are unacceptable, such as repeated insults, yelling, and the like. The therapist can then formulate an effective intervention that sets limits while also letting the client see, and feel, the emotional impact she is having on the therapist. The point I am making here is that there is plenty of room for individual differences in responding, and the therapist naturally should reflect on whether or not she is overreacting. The technical issue is emotional honesty and availability, not that one type of emotional response or way of speaking is better than another.

COUNTERTRANSFERENCE ANGER AND HATRED

Although the two-person approach that has developed over the past 20 years frees up therapists to feel more for their clients, the conversations about anger rarely go beyond the mention of occasional frustration and irritation. Anger, rage, or hatred are often associated with negative therapeutic reaction and negative outcome. Although I do not dispute the literature on the likelihood of a negative outcome when the therapist's attitude toward the client is predominantly negative, I believe we have given short shrift to the benefits of acknowledging anger and hatred in the countertransference when a stable, positive attachment between therapist and patient exists. If the client feels safe, then there is ample room for the appropriate disclosure of therapist anger. Even though Winnicott's (1949) classic paper on the necessity of hate in the countertransference is often quoted, the topic rarely makes it into actual discussions on technique.

Many therapists feel so much guilt about their anger that they split it off completely. This problem can only be addressed adequately by personal treatment. But, from my own experience, most therapists are aware of their negative feelings, and the affect literature supports the conclusion that strong negative feelings are the ones least likely to be out of awareness. Again, the problem often lies with the fact that therapists feel that they should unconditionally accept and care about their clients. When they do not, they may blame themselves and feel guilty and inadequate.

Doesn't anger or hatred implicitly imply a rejection of the client's behavior, attitudes, or values? How do we integrate the possibility for negative judgments with an attitude of openness, curiosity, and acceptance? Can we let a client know that he is behaving badly, trusting that our assessment is both accurate and fair? Are there clients who cannot get better without this type of feedback? I think we have done too little experimentation in this area, indulging fears that our clients cannot bear any negative feedback from us.

When are you doing the absolute best for your client by letting him know he is out of line? And when are you foreclosing his anger and disapproval of you because you cannot tolerate this assault on your "good enough mother" persona? Although many of these items are obvious, I want to take a moment to list some of the client behaviors that are likely to stimulate irritation, anger, and, over time, even hatred in most therapists. They include:

1. Repeatedly insulting the therapist, either professionally and/or personally.
2. Compulsively talking at the therapist, while showing no affect.
3. Making excessive demands for extra time, phone calls, or contact outside the office.
4. Repeatedly denying that any progress has been made, even when it is substantial.
5. Remaining silent for extended periods and/or refusing to begin the session.
6. Being chronically late for sessions, or canceling at the last minute.
7. Waiting to be confronted about delinquency before paying the bill.
8. Intruding into the therapist's personal life.

This list is not exhaustive, by any means, but it illustrates my point regarding therapist anger as a normal, everyday event. Rather than going away on their own, these client behaviors are more likely to persist or intensify if the therapist ignores them. As I pointed out elsewhere (Maroda, 1991), many clients up the ante when they fail to get an emotional response from their therapists, until either a blowup or withdrawal into depression break the momentum.

Whether or not the therapist feels anger depends to some degree on the client's intent, as well as the therapist's capacity for experiencing anger. Some clients criticize the therapist, for example, when they are covering up a deep hurt. The resulting countertransference affect is more likely to be tenderness and empathy than anger. The hallmarks of countertransference denial of anger are withdrawal, masochistic submission, or exaggerated love.

There is no doubt that therapists routinely deny or suppress their anger or hatred at clients for fear that they will be sadistic and destructive. Is this a realistic fear? The inevitable answer is "yes and no." Gabbard (1996a) notes that sadomasochistic reenactments can occur when the client stimulates rage in the therapist, who ultimately lashes out, sadistically fulfilling the client's expectations for rejection and punishment.

Safran and Muran (2002) cite the abundant literature stating that "poor outcome cases show greater evidence of negative interpersonal process (i.e., hostile and complex interactions between patients and therapists) than good outcome cases" (p. 1). Therapists need to be careful about disclosing negative reactions to the client before an atmosphere

of trust and safety has been established. Even then a sadomasochistic relationship is still possible. How do we avoid this? Langs (1974) says that the sadomasochistic alliance occurs most often when the therapist *denies* his anger, rather than when he is aware of it and/or discloses it. The same is true with sexual contact and other forms of acting out. Awareness and acceptance of countertransference feelings helps facilitate a positive outcome, while denial breeds acting out.

THERAPIST PASSIVE–AGGRESSIVE BEHAVIORS

Recent research on affect supports the notion that all affect is communicated, even if only unconsciously. So therapists who believe they can hide their anger, rage, or hatred from their clients are only fooling themselves. And if any person stays angry long enough or often enough, that anger will be expressed in some form. So what do angry therapists do? They are passive–aggressive. Langs (1973) says:

> The use of silence—"the silent treatment"—to express conscious or unconscious hostility is well known. Therapists are not immune to such uses of silence. Thus, when they feel provoked, annoyed, or enraged by a patient, they may fall silent either to punish the patient directly or defensively and primitively to withdraw from him. (p. 380)

Therapist withdrawal can quickly lead to impasse as the patient responds with intensified anger and a demand for a response from the therapist. Further silence or avoidance from the therapist creates a downward spiral that may last for many sessions.

Other examples of passive–aggressive therapist behaviors include some of the same provocative behaviors I listed previously as exhibited by clients, such as chronic lateness or ending sessions early, unnecessary rescheduling, missed appointments, pejorative comments and interpretation about the client and/or her loved ones, withholding acknowledgment that the client has changed, falling asleep, and "forgetting" important details reported previously by the client.

Celenza (1998), in her study of precursors to therapist sexual misconduct, noted that transformations of love and hate in the countertransference were particularly salient. Converting countertransference hate into countertransference love frequently precedes sexual abuse of the client, a hypothesis made earlier by Searles (1979). So when countertransference anger and hatred are denied over time, the best-case

scenario is a failed treatment, the worst-case scenario is sexual abuse of the client.

If we start from the proposition that countertransference anger and hatred are normal and expectable, and that awareness and acceptance of these feelings is essential for therapeutic success, where do we go from there? Can we allow ourselves to see the worst in our clients and ourselves without losing hope? How do we decide when to disclose our negative feelings, especially since timing appears to be critical? When is it better to acknowledge these feelings silently and manage them internally? If we do express anger or give negative personal feedback to a client, how do we know if it was therapeutic?

Also, how can we avoid feeling guilt and shame when we have violent or murderous fantasies about our clients? Should we ever share these fantasies with the client? And how can we understand what seem like shocking and uncharacteristic feelings of hatred or violent fantasies and still maintain our equilibrium and positive self-image?

Epstein (1979) reports that when he was in training he asked a supervisor how to deal with a difficult patient who had made little progress after 6 months. The supervisor advised him to be more confrontive and show anger. Epstein recalls being freed by this advice: "This statement was sufficient to dissipate the image I had created of my patient as a vulnerable, love-starved child. I now saw her as a nasty, withholding, contemptuous, uncooperative bitch, and I reacted to her accordingly" (p. 213). He goes on to say that he confronted her about her negative behavior, her silences, and her contempt. He said she responded with anger initially, but then made "amazing progress."

Interestingly, he then says that disclosing hostility to masochistic patients who are provocative may produce masochistic gratification rather than therapeutic gain. So clearly the disclosure of anger toward the client requires not only the awareness of anger, but also a judgment call regarding the client's motivations for provoking anger. Here the therapist may be guided by the client's past relationship patterns. Does the client have a history of sadomasochistic relationships? If so, is he usually the aggressor or the victim of aggression? Clients who are self-identified as victims may be more likely to provoke the therapist into showing anger before a positive relationship has been established, or into sadistic enactments rather than constructive expressions of anger.

In the spirit of mutuality, the therapist should also ask herself if she is feeling the need to punish or harm the client. Does *she* have a history of getting fed up with people, then acting sadistically toward them? Does she have a history of being masochistic and prompting oth-

ers to take advantage of her or to act sadistically toward her? Everyone has the potential for engaging in sadomasochistic enactments, and will. The question isn't "Will I?" or "Could I?" The question is "Am I being masochistic or sadistic in this moment?"

Gabbard (1995) cited a study of therapy with clients with BPD where the therapists had become overtly angry. Both therapists and clients were interviewed after these sessions regarding the therapeutic value of the therapist's expression of anger. The therapists uniformly felt that they had behaved badly and nontherapeutically. The clients, however, reported that they felt the sessions were quite helpful, except in instances when the therapist was out of control.

Dalenberg (2004) wrote about the role of anger in treating trauma survivors. She notes the prominence of anger in trauma survivors and the frequency with which they stimulate anger in their therapists. Like Gabbard, Kernberg (1975), and myself, she argues that the "blank screen" approach produces poor results. Yet she is wary of Gabbard's conclusion that the disclosure of therapist anger can be highly therapeutic. Her research concluded that the therapist taking responsibility for her part in the conflict following an expression of anger was therapeutic. She wonders if it is this acknowledgment of joint responsibility that produces the therapeutic benefit, rather than the expression of anger.

Perhaps it is both. I agree with Dalenberg (2004) that once a therapist expresses anger, the client is inclined to point out what behaviors in the therapist contributed to the conflict, or how he could have managed the conflict better. In the spirit of a truly relational and interactive approach, the therapist must certainly own up to his own participation. But I think Dalenberg's position does not sufficiently incorporate the notion of completing the cycle of affective communication. Even her view subtly implies that therapist expression of anger is not, in and of itself, potentially therapeutic.

My clinical experience supports what both Gabbard and Dalenberg report, in that clients value honest emotional feedback. I think the bias against expressing anger has more to do with the aforementioned therapist tendencies to avoid conflict, and the resulting reality that many therapists only express anger involuntarily. That is, they do not so much *choose* to express their anger, having become aware of it and feeling in control. Rather, they find themselves blowing up, which produces guilt and shame. It also frightens the client and does not serve as an example of affect regulation.

Therapist training would ideally involve role playing that included

expressing a variety of emotions, including anger, to clients. Therapists in training would benefit greatly from the inclusion of assertiveness training into their graduate programs. It could help them overcome their natural aversion to conflict and teach them how to identify and express negative feelings constructively.

When the therapist assumes the masochistic role in relation to the aggressive client, even if that client traditionally has been the nail rather than the hammer, there is no therapeutic benefit. It is simply a role reversal with a sadomasochistic dynamic. The literature and my own experience point to several key factors in expressing countertransference anger or hatred constructively.

GUIDELINES FOR EXPRESSING ANGER

1. *The therapist must be reasonably in control, while still showing emotion*. As stated previously, the therapist's role is to model affect management. Being out of control will frighten the client and reinforce the notion that anger is dangerous. Conversely, a too cool and calm, emotionless response fails to engage the client and will also fail to be therapeutic.

2. *The anger must be direct, honest, and as nondefensive as possible.* I realize this is a tall order, given that everyone gets defensive when attacked, including therapists. But often taking a minute or two to process your feelings internally, including understanding why the client is being provocative, can help reduce defensiveness. The client's accuracy may also stimulate defensiveness in the therapist.

3. *Since the client is likely to come back with some statement of how the therapist had a part in the client's anger, it is always best to admit this, even if it seems a bit absurd.* Again, viewing the conflict as relational, rather than residing within the client, requires the therapist to take responsibility for any behavior that offended or alienated the client—no matter how large or small the contribution. The processing of transference–countertransference anger is often derailed by the therapist's resistance to being emotionally vulnerable to the client, particularly if that client is critical and difficult. But if the therapist does not give over, the client will continue to attack. The therapist then strengthens his defensive wall and the result is impasse. Sometimes the therapist's introspection may result in an admission of hurt or humiliation that was defended against with anger. Therapists who need to feel in control at all times will have particular difficulty admitting that the client has hurt them.

4. *Stay in the realm of emotion.* The chief value of emotional feedback is that it completes the cycle of affective communication, freeing the client to move beyond being stuck with an unacceptable feeling. Disclosing aggressive fantasies like "I had an impulse to hit you" run the risk of terrifying the client and destroying the essential atmosphere of safety.

• *Example:* Roger, a rich lawyer, repeatedly tells his therapist that the therapist is incompetent and an idiot. Then he waits for the therapist's response. The therapist has been ignoring these remarks, which has only resulted in Roger's making them more often. The therapist is understandably becoming silently enraged and is retaliating in his mind against the client with similar insults. In the sessions, however, he remains silent or asks Roger to explore his negative feelings toward him. Roger does not do this. Instead, he changes the subject and waits until the next session to insult his therapist again. This repetition qualifies as masochistic submission on the therapist's part.

• *In-control response* (with appropriate eye contact and facial expression of emotion): "Look, Roger, you've been insulting me almost every time we meet, and I am frankly getting quite irritated by your behavior. I am not going to tolerate being called an idiot any longer, but if you would like to talk to me about what is behind these angry remarks, I'd be glad to hear what you have to say."

• *Out-of-control response* (with corresponding facial expression of rage and angry tone): "Well, if you think I'm such an idiot and not worth your time, maybe you should find another therapist."

• *Passive–aggressive response* (with little or no affect, disguised anger): "You know, Roger, I can't help but notice that even though you've lost your last six cases, you regularly refer to other people as idiots."

• *Possible contribution from therapist:* Roger may be responding to a lack of interest by his therapist or to a lack of verbal responsiveness. Why is he calling his therapist an idiot? What is the context and what does it tell you about Roger's motivations and his feelings about therapy? Did his therapist inadvertently reveal feelings of envy with Roger, who is wealthy and successful? Or is Roger combative and demeaning with most other people? The above interventions are examples, and the needed intervention can only be determined within the context of what is happening in the moment between Roger and his therapist. However, Roger's history regarding anger, insults, and competition, as well as the therapist's history, are all relevant factors to consider. Even

if Roger insults his therapist out of deep feelings of inferiority, he probably does this with other people also, and it remains the responsibility of the therapist to give him feedback he can use productively.

Therapists can help prevent out-of-control expressions of anger, and their potential for forced terminations, by not treating people they dislike, as I mentioned in Chapter One. Especially with difficult clients, a strong, positive relationship needs to be in place for both parties to weather periods of intense anger and criticism.

Research on the unconscious has taught us that people know within a few minutes whether or not they like each other and want to relate to each other. If you do not like a particular client at first sight, do not override your internal response, even if you do not understand it. Your feelings will not be lost on your client and will make difficult interventions, like expressing anger, almost impossible to pull off.

There is no question that disclosing anger or hatred toward a client presents a challenge. It is not something any of us would do without some forethought and in response to provocative behavior by the client. Certainly, taking a moment to look inward and examine whether or not you were angry about something before the client arrived is advisable. Disclosing any emotion effectively can be difficult and requires practice. Responding with anger needs to be done judiciously, preferably in response to a pattern of aggressive or passive–aggressive behaviors and/or a direct request by the client to know what the therapist is feeling (Maroda, 1991).

SUMMARY

Therapists' early roles as comforters and peacekeepers in their families of origin serve to develop both their greatest strengths and their greatest weaknesses. The tendency to avoid conflict helps with early empathy but hinders assertiveness and confrontation. Clients can benefit greatly from simple confrontations regarding basic life issues and contradictions between their feelings and their behaviors. With clients who are abusive, demanding, and have difficulty with limits, it is vital that the therapist be capable of strict limit setting and providing affective feedback.

As difficult as disclosure and working through the angry transference–countertransference may be, the alternative is likely to be withdrawal, passive–aggressive behaviors, or the transformation of thera-

pist hate into therapist love—all events that undermine the pursuit of the truth and destroy the treatment. Viewing therapist anger through the same lens as client anger, that is, trying to understand and accept the feelings as normal and natural, while also being introspective about what is happening in the relationship, can result in its healthy and therapeutic expression.

9

Erotic Feelings

How They Help or Hinder the Therapeutic Process

> The term *erotic transference* has a reassuring clinical ring to it. By contrast, to hear a patient say, "I love you," sounds too personal, too close for comfort.
>
> —Glen Gabbard (1994, p. 156)

I recall feeling routinely overstimulated as a young therapist when my clients declared deep feelings of love or romantic interest in me. One of my first clients in private practice, whom I will call John, was 5 years younger than I was and chose a female therapist because his father had been denigrated in the family. His mother was uneducated but fiercely intelligent. She engaged John in intellectual debate from the time he was a boy and he considered her responsible for his success as a corporate attorney. John idealized me from the onset of treatment and soon proclaimed his feelings of love for me. He regularly informed me that he was a wonderful lover, but perhaps a bit overconcerned about pleasing women due to his need for his mother's approval.

One day he turned to me and spoke of his desire to be close to me and please me sexually. He related a fantasy he had centering on a tender and loving event of sexual pleasure for me. I was immediately aroused, and then blushed with shame over my feelings of arousal. John noticed my reaction, stopped talking, and then changed the subject.

John's change of topic was both a relief and a shameful confirma-

tion that he had observed my reaction. We both muddled through the rest of the session without incident. Afterward I tried to process what had happened between us. I knew John was sincere in his affections for me, but his overt seduction also meshed with past comments he had made that indicated he was competitive with me and needed to have more power in the relationship. I observed in his relationships with women he seemed to need to dominate them, but veiled this by being sensitive to their needs and always promoting their interests and noting their talents. Did John simply want to dominate and covered this need with pseudoaltruistic motives? Or did he want to be intimate and nurturing, but felt too vulnerable if he didn't also have the upper hand?

And why was I so embarrassed and discombobulated? Did I need to be in control and couldn't cope with John turning the tables on me? Or was I just too unprepared for feeling aroused by a client? Although I learned to manage my feelings better as his treatment progressed, in that moment I was unable to help John explore his feelings for me, and inadvertently declared them shameful through my response of blushing and general discombobulation. I am presenting this case example as an introduction to the following in-depth discussion of erotic transference–countertransference, which includes the power dynamics that may be involved.

At the time I was treating John it was considered unseemly for therapists to have sexual feelings in response to their clients. Moreover, clients who persisted in feelings of love and sexual attraction to their therapists were considered to be acting defensively and "resisting" the real work of treatment. Therapists who reciprocated even a modicum of love or a hint of physical attraction were considered to be caught up in a moment of unenviable weakness. At the same time, it is clear that some clients, and some therapists, do focus on the erotic aspects of the relationship as a way to avoid vulnerability and gain power. This chapter is devoted to exploring this complex issue and helping therapists better understand both their clients' and their own sexual feelings in treatment.

Historically, the prevailing question on this topic has been: What is the underlying meaning of expressed erotic or loving interest? This question used to be answered solely in terms of the client's motivations, without regard to any provocation by the therapist, and was most often regarded as defensive. Now we are more willing to consider that erotic or loving interest has as much potential for being a healthy expression of the client's adult capacity for attachment as it does for being defen-

sive or pathological. The therapist's role in creating an erotic or loving relationship has also been recognized.[1]

Gabbard (1994) has said that the old attempt to distinguish between transference love and love outside the treatment is essentially a waste of time. I agree with Gabbard that it is gratuitous to question the validity of the client's feelings when they "sue for love," and as equally gratuitous and defensive for therapists to deny their love and sexual feelings for their clients. Maintaining appropriate boundaries, including refraining from expressing sexual interest in clients, does not preclude accepting and being curious about these feelings when they do occur.

As with any deep emotional issue, the therapist ideally maintains a delicate balance between avoidance and indulgence. It is common for beginning therapists to feel overwhelmed by their early experiences with clients falling in love with them. From my perspective, the less guilt about this, the better. The ideal therapeutic goal is to bring the same respect for the client's feelings and the same open attitude of curiosity and matter-of-factness that you would bring to any of the client's emotional experiences. Neophyte therapists often have to process much of their countertransference outside of the sessions, particularly when a favorite client declares undying love or a desire to have sex.

New therapists may alternately feel guilty, aroused, generally overstimulated, afraid of being out of control, or even defensively angry. As Gabbard (1994) implies, therapists receiving expressions of love from their clients may be overwhelmed, finding it difficult to integrate these very personal feelings into the professional relationship. Or they may find their clients' love too gratifying, and encourage it to their clients' detriment. It is up to the therapist to accept the client's feelings while still maintaining his or her own equilibrium and maintaining the boundaries.

MAKING THE DISTINCTION BETWEEN THERAPEUTIC AND NONTHERAPEUTIC EROTIC TRANSFERENCE

Much of this chapter is devoted to the difficult issue of determining how much erotic interest on the client's part is therapeutic and, like

[1] I recommend Mann's (1997) extensive review of the literature on erotic transference–countertransference, with an emphasis on its positive contributions to the overall therapeutic experience. For more elaborated discussions of love in the therapeutic relationship, see Coen (1994, 1996) and Bridges (1995).

regression, when it ceases to be therapeutic and become an obstacle to any real treatment taking place. Even clients who usually express their loving or romantic feelings in a constructive way may fall into using these feelings defensively at times to avoid grieving. The grieving being avoided may involve the unavailability of the therapist for a real relationship, or it may be another loss that feels overwhelming to the client. When the client who at first seemed taken with the therapist in a manageable, therapeutic way becomes obsessive, it is time to wonder about what he or she might be avoiding.

From my experience, all obsessions represent an avoidance of something more painful. A client who obsesses about wanting a personal relationship with the therapist is probably defending against unbearable feelings of loss or emotional annihilation. But sexual obsession may also mask envy, hatred, or competition with the therapist. This is where the uniqueness of each relationship comes into play. It pays to have an open mind about what the client may be avoiding. To paraphrase an earlier quote from Ferenczi (1976), the therapist would do well to keep an eye open for any unconscious negative reactions to the therapist and bring them relentlessly into the open. I think this applies particularly when the client obsessively "loves" the therapist.

Other signs of a problematic erotic transference include any type of spying on the therapist or certainly stalking him, demands for personal information that keep escalating, demands for extended or additional sessions, demands for physical contact, or demands for disclosure of any sexual interest on the therapist's part. Both therapist and client may be aware of an erotic aspect of their relationship and not realize it is out of control until some untoward event occurs. The therapist may wonder how this happened. Why is the client defending so wildly against being vulnerable in the treatment? What, if anything, is the therapist doing to stimulate these feelings and behaviors? And how are these issues resolved, particularly if the client is reluctant to examine them?

When the erotic transference becomes nontherapeutic, it is critical that the therapist be willing to consider how he or she may have contributed to this dilemma. Langs (1974) outlines seductive behaviors on the therapist's part that help create a nontherapeutic erotic transference. These include comments on the client's attractiveness; excessive interest in the client's sexual behavior and fantasies; deviation from normal practice as a special indulgence for that client; overemphasis on the client's sexual interest in the therapist; self-disclosure of erotic feelings toward the client; and touching the client. Errors or overinvolvement with a client are often only identified after a problem mani-

fests itself. This is especially true for new therapists who must painfully learn from their mistakes. A well-intentioned therapist who suddenly realizes she has been seductive with a client will appropriately cease these behaviors.

However, a new problem may arise when the therapist attempts to correct her therapeutic error. The therapist may precipitously distance herself from the client, as mentioned previously, resulting in an experience of painful rejection for the client. It is vitally important that the therapist not compound the original error of having been too seductive by then becoming rejecting, cold, and abandoning.

A poignant example of this latter point can be seen in Carter Heywood's (1995) *When Boundaries Betray Us*, which documents the mutual seduction by Heywood and her therapist, ending in traumatic rejection for Heywood. Following many sessions during which both of them sat on cushions on the floor amid a room filled with lit candles, Heywood proclaims her love for her therapist, and wants the promise of a friendship after termination. The therapist responds by panicking and distancing from Heywood, never returning to the blissfully sensual state in which they had previously functioned. Heywood's sense of betrayal is palpable and understandable. Her therapist seduced and abandoned her. Heywood argues that her therapist should have agreed to a friendship after termination, but I disagree. Her therapist shouldn't have established the romantic relationship between them in the first place. Once created, it served as a huge obstacle to Heywood giving her therapist up and doing the requisite grieving over this loss.

The phenomenon of the therapist who engages in mutual seduction with a client, then dumps her when things get out of control, is not uncommon. Nor is it uncommon for a client to seduce and abandon her therapist. I find that few therapists are prepared for this scenario and have significant difficulty when they realize what has happened. The lack of closure in the relationship produced by abandonment can be equally troubling to the therapist who has been abandoned. The client or therapist who fears vulnerability, but wants to be loved, may routinely seduce and abandon others.

DEALING WITH THE CLIENT'S RELUCTANCE TO DISCUSS EROTIC FEELINGS

Many clients resist the idea of talking about feelings that can never be acted on. They often say, "*What's the point?*," which is just another way

of saying that they feel embarrassed or even humiliated by pursuing this subject and wonder what the therapist's motivation is for encouraging it. The client wonders, "Do you wish to make a fool of me? Or do you take sadistic pleasure in my being so exposed and vulnerable? Or do you enjoy the admiration or sexual arousal that you feel when I speak of my feelings for you?" The client may say, "Okay, I understand why we can't have a sexual relationship, but then let's drop it and go on to other things. Why should we keep talking about it?"

It is at this point that the therapist discusses with the client the need to express any and all feelings for the sake of self-awareness, acceptance of feelings, affect management, the acquisition of insight, and the opportunity to grieve what cannot be. Exploring the client's fears of humiliation, objectification, rejection, and overstimulation can help her to understand why it is necessary to express whatever strong feelings she is having. Not surprisingly, many clients who resist the expression of their romantic feelings for the therapist harbor a secret fear that they will succeed in seducing the therapist and destroying the treatment. Others consciously or unconsciously know that they have been seduced and are resisting this power move on the therapist's part.

LOVE OR POWER?

Although I have made the point here that genuine loving and romantic feelings can be part of the therapeutic process, there are clearly some clients who are seductive in the interests of conquest. They are aggressively sexual, combining a demanding hunger for power and control with their sexual desire. These clients are the ones who have great difficulty accepting the asymmetry of the therapeutic relationship. They fear helplessness, rejection, dependency and, ultimately, psychic annihilation. Wry and Welles (1994) describe this attitude as "erotic terror" and Kumin (1985) as "erotic horror." Often having been physically and/or sexually abused as children, these clients essentially protect themselves in the therapeutic relationship through the zealous seduction and courtship of the therapist.

This type of aggressive erotic approach manifests a desire for pure power, typically begins very early in the relationship, and is not the constructive, positive burgeoning of loving and sexual feelings that most authors are referring to when they speak of a healthy erotic transference. In accordance with mutuality, it is fair to note that some therapists

have similar fears of intimacy and vulnerability and need to sexually seduce their clients for their own protection.

In his classic paper Blum (1973) attempted to distinguish between the more expectable loving, erotic transference and the sexually aggressive, power-driven one. He created a different category for these difficult clients and did so by coining the term "erotized transference" versus the standard "erotic transference." Blum cites Gitelson (1952) when he describes those with erotized transferences as "people who demand to be loved in the absence of a capacity for love" (p. 62). Elaborating on the nature of their attachment, he remarks:

> These are not ordinary reactions of transference love, and these clients can resemble intractable love addicts. Their erotized transference is passionate, insistent, and urgent. While conscious discomfort and guilt may be present, the guilt may be isolated and unconscious. The conscious fear is not of regression or retribution, but of disappointment and the bitter anguish of unreciprocated love. Through projection and denial they can assume their therapist indeed loves them. For the borderline clients manifesting this reaction, transference and reality may be dangerously confused. There is the threat of regressive loss of reality testing. (p. 64)

When Blum says that such clients defensively imagine that the therapist reciprocates their feelings, the implication is that the therapist clearly does not. Instead, the therapist experiences the client as aggressive and assaultive. Making the distinction between loving and aggressive erotic transferences may seem simple at first glance. But many people appear at first to be gentle and loving, only becoming aggressive well into the treatment, when the threat of emotional annihilation surfaces or when the therapist herself becomes too seductive and overstimulating.

Distinguishing between an intense but essentially positive erotic transference and a defensive or aggressive one can be especially difficult if the client fluctuates from one to the other. I think a key variable in making this discrimination is the countertransference. When I treat a client with the aggressive sexual transference described by Blum, my reactions range from curiosity and interest to irritation and frustration, and eventually to helplessness and rage. Even during more peaceful or enjoyable moments with the same client, I rarely reciprocate the feelings of love and sexual desire.

I can know something about the client's motivations through my own internal emotional responses. Something is wrong when a client

persists in declaring undying love for me and I *do not feel loved at all.* As Blum points out, those who demand love are usually incapable of it. Instead of feeling loved, I usually feel assaulted, and work overtime to maintain proper boundaries in the face of all manner of intrusions on my privacy and attempts by the client to control the treatment.

The example of Nancy, whom I spoke of earlier in the discussion of countertransference anger, fits well into this discussion. Nancy wanted everything from me. She alternately wanted me to be her mother, her best friend, or her lover. The reader may remember that I said I distinctly did not feel loved when Nancy was berating me for not loving her enough and not being willing to fulfill any of these roles in her life. After much consideration, I ended up telling her what I really felt in these moments, which was frustration, anger—even hatred. Similarly, in the case of Susan, who wanted me to love her and hold her, I had to let her know directly not only that I was not going to provide the physical contact she demanded or pleaded for, but that I did not really want to.

With a client who seeks love more than power, my countertransference is different. I feel a warm expectation of seeing the client whose love is not essentially defensive and who inspires a reciprocal deep affection or love in me. If I feel any anxiety or apprehension, it is born out of a sense that I might lose my emotional equilibrium. As a new therapist I often became uncomfortable—even going so far as to change the subject. I did not receive any education during my training about having, and managing, sexual or loving feelings toward my clients.

When I felt aroused by a client's expression of sexual interest in me, I felt guilt or even shame. As a young therapist, I'm not sure I knew the difference between feeling the pull to act on my feelings and actually acting on them. So I had to cut them off. Without really thinking it through, it seems that I felt that having my sexual and loving feelings toward a client might lead to abusing a client—something I could never accept doing.

Early in my career I did not realize that a degree of emotional gratification for the therapist is not necessarily unseemly. I believe I would have been less disturbed by my erotic and loving feelings toward my clients had I realized that without *some gratification* (Maroda, 2005), there is no relationship. The delicate balance in the therapeutic relationship is one of finding enough gratification to keep therapist and client invested, yet frustrating both therapist and client in their deepest desires, which often center on filling voids from the past. The gratifications I speak of do not involve crossing the professional boundaries

in any way. Rather, they revolve around the acceptance of loving and erotic feelings, experiencing and allowing the pleasure of those feelings without feeling guilt or shame.

Searles's (1979) famous comment about feeling in love with all of his patients, male or female, at some point in the treatment (and even imagining marrying them) speaks to the naturalness of loving and erotic feelings in a deep psychotherapy. Searles never acted on these feelings, never expressed them to his clients, and made it clear that he did not advocate doing so. Searles understood that the ideal therapeutic stance was one of manageable affect engagement.

Erotic or loving feelings are not problematic unless they become consistently obsessive, interfere with the therapist's ability to keep the boundaries, or lead the therapist to defensively withdraw. Searles talked about how parents who notice their children too much as they are developing sexually may defensively withdraw from that child or become sadistic and rejecting. When a client re-creates that scenario in therapy, it is critically important that the intensely engaged therapist not make the same mistake as the parents did, thus repeating past damaging events. In order to accomplish this, the therapist must be capable of accepting the loving and erotic feelings without experiencing the guilt that forced the parent(s) to withdraw.

In the event that either therapist or client cannot manage these feelings, which I do not believe needs to happen as often as it does, it may be necessary to think about referring the client out to someone else.[2]

ACCEPTING AND MANAGING THE EROTIC COUNTERTRANSFERENCE

Much remains to be explored regarding the productive use of sexual feelings in the therapeutic endeavor. When a client expresses love or sexual desire toward me, as with everything else, there is a part of me that rightly asks, "Why now?" This attitude is not inconsistent with being emotionally available. There is plenty of room to receive the client's feelings, accept my own feelings, and still ask, "Why now?" Within the relational paradigm, the answer to "Why now?" may or may not have as much to do with the therapist as the client. Unfor-

[2] I spoke in *The Power of Countertransference* (1991) about the importance of doing this with the aid of consultants and avoiding a precipitous ending that might traumatize the client.

tunately, the literature is replete with examples of therapists who, in examining there own sexual feelings toward their clients, inevitably attribute the origin of their feelings to the client's conscious or unconscious seductions. Traditionally, the therapeutic attitude was, "If I am sexually aroused, then the client is seducing me." While this may be true at times, it certainly cannot *always* be true. Often, the reality is that the seduction is mutual, as it is in most human relationships. At other times it is the therapist who is the seducer.

Now that love and desire are accepted in the therapeutic relationship, curiosity, rather than guilt or shame, has become the order of the day. Therapists can examine the potential contributions of both therapist and client, clearly aware of the issues and underlying vulnerabilities, yet still assign some responsibility. For example, persons who have been sexually molested are more likely to be seductive with everyone, including their therapists, because this is the relational pattern they know (Mitchell, 1988). Moreover, these individuals are much more likely to have sex with their therapists than those who have not been sexually abused (Pope, Sonne, & Holroyd, 1993). A less well-known reality is that therapists who have been sexually molested are also much more likely to have sex with their clients than those who have not (Margolis, 1994; Kernberg, 1994). Indeed, they are more likely to have sex with a client who is also a therapist. Keeping in mind the vulnerabilities of both therapist and client can help to prevent boundary violations and failed treatments.

Although the aggressively sexual clients described by Blum may present the most difficult situation of erotic transference, this type of client is the exception rather than the rule in most practices. Lester (1985), Goldberger and Evans (1985), Altman (1995), and Gabbard (1994) have stated previously, and I concur (Maroda, 1991), that the therapist who has sex with this type of client often does so as much out of rage and a desire to punish the client as anything else (Searles, 1979; Celenza, 2003, 2007). It is when the countertransference frustration and rage go unexpressed and unresolved that aggressive sexual events occur. So this type of case might be better discussed under the rubric of "countertransference aggression."

Whether dominated primarily by love or aggression, Person (1985) reminds us, sex is power. So when the therapist asks herself, "Is this client trying to influence me through his erotic feelings," the answer is inevitably "Yes, of course." The literature on affect tells us that one of the purposes of *any* emotion is to influence the receiver. Therefore, a more constructive question is, "What does this client

want from me at this moment in time?" Or, if the countertransference is being examined, "What do I want from this client at this moment in time?" In what direction is each of us attempting to move the relationship?

Gabbard (1995) points out that the more mature, reciprocal feelings of sexual attraction and love often come as the client is approaching termination. In the throes of separation anxiety and anticipated loss, both parties may find themselves experiencing longing and sexual desire. But this does not preclude such feelings from occurring at any point in the therapeutic relationship. I have personally found that I am more likely to be sexually attracted to clients during the early "honeymoon" period. Later, as the inevitable conflicts arise, I find that my clients' litany of my faults or deficiencies serves as a cold shower.

Are erotic feelings part of the natural flow of the relationship, moving it along toward greater depth and understanding? Or is this an interruption? Is it an attempt to block any meaningful emotional connection? Is it a defense against anger or grief? Is it an attempt to feel powerful rather than weak and dependent or afraid? Has either party slipped into the gray zone of a fantasized sexual healing taking place if only they could become lovers? These are all appropriate questions for the clinician to ponder when a strong erotic and/or loving relationship develops in treatment.

TRAUMA VICTIMS AND "OEDIPAL WINNERS"

Trauma counselors report that clients who have been sexually molested at an early age are more likely to be seductive with everyone, including their therapists. In the past, therapists had a tendency to blame the client for relating to the therapist in a sexual way. This was seen as an attempt to destroy the treatment rather than as an attempt to build a meaningful therapeutic relationship. But after decades of studying the effects of parental seductiveness on children, therapists now understand that clients whose primary attachment figures were seductive naturally attach this way to others. Seductiveness becomes ingrained in the attachment style and is simply what the client knows and unconsciously repeats as a way of connecting with others.

Having learned this way of relating at an early age, clients who are either victims of sexual abuse or who are "Oedipal winners" will be more seductive in the therapy relationship. The term "Oedipal win-

ners" as it is used here refers to persons who were highly favored, and perhaps overvalued, by a parent who did not molest them, but injected sexual overtones that were not appropriate to the parent–child relationship. Their seductive relational style may mimic that of clients who have been abused, which sometimes leads therapists to inaccurately assume overt abuse where none exists. The term "double Oedipal winner" was coined to describe the person who was the recipient of a sexualized overinvestment by both parents. These are outdated and informal terms, of course, but descriptive nonetheless.

One of my young female patients, Kristen, was seductive with both men and women. Her attachment style was infused with a high degree of sexuality. When I asked about her childhood and the nature of her relationship with her parents, she said some of her father's behavior gave her the "creeps." She reported that he was always watching her in a way that did not seem "fatherly" to her, even though he never touched her inappropriately. He also watched pornography quite frequently and would guiltily switch it off when she walked into the family room. Both he and her mother were overprotective and obsessed with her comings and goings, as well as with her diet. As an only child, she was the singular focus of family life, and experienced her parents' attention as extremely intrusive and "odd." She had never been molested, but found herself engaging in sex play with other children by the time she was 10 years old.

In her early relationship with me she was constantly adjusting her clothing and sweeping her long hair back and forth during her sessions. She did not dress inappropriately for her sessions, but she crossed and uncrossed her legs frequently and touched herself more often than most people do. My reaction to all of this was to simply ignore it, which seemed quite relieving to her. I noticed her behavior, of course, noting that it seemed more like how a young woman would behave on a first date.

But I recognized this as being her normal style of talking and gesturing and did not make any reference to it at all. Nor did I find it uncomfortable. Had she been dressed inappropriately, or touched herself inappropriately, that would have been a different matter. Under those circumstances I would have mentioned it to her as gently as possible, so as to make her aware of her behavior, but minimize the potential for hurting or humiliating her. As an addendum, as her therapy progressed and our relationship became more secure, her flirtatious behaviors became infrequent and barely noticeable.

THERAPISTS WITH A SEXUALIZED ATTACHMENT STYLE

The literature has alternately reported that therapists who have been molested are more likely to have sex with their clients (Pope, 1994; Kernberg, 1994), and that they are *not more likely to do so* (Celenza, 2007). Perhaps it is the therapist with a sexualized attachment style who is more likely to engage in abuse. Therapists who do commit sexual boundary violations often do so with another therapist (Margolis, 1997). Why this occurs so frequently is unknown, but it may be linked to the early childhood experience that is shared to some extent by persons who become therapists. It seems likely that therapists would be more likely to attach strongly to each other, especially since both could potentially be highly empathic in their responses. This last point fits with the description of the typical victim of therapist sexual abuse provided by Celenza (2007), who contradicts the notion that most victims are very difficult people:

> Another myth that must be dispelled is the notion that all victims of sexual boundary transgressions are borderline women. … The victims of sexual boundary transgressions span the full range of diagnostic categories and the majority are highly appealing women who tend toward meeting others' needs at the expense of their own. (p. xxiv)

A number of therapists have reported to me that they became involved in sexual or social relationships, during or after treatment, with their therapists. And most of them said they had *not reported it*. The chief reasons for this appear to be avoiding being seen as a victim; avoiding being exposed to subsequent negative publicity in their communities; and avoiding being seen as attacking their therapist—who is usually a well-respected, established member of the local mental health community. So it seems advisable for any therapist to be keenly aware of the potential for boundary violations when treating another mental health professional, as well as when going for one's own therapy.

GENDER DIFFERENCES IN EROTIC TRANSFERENCE–COUNTERTRANSFERENCE

Person (1985) was the first to note the differences in expression of erotic transference on the basis of gender. She reports that "women in general

appear to experience more intense and fully developed erotic transferences" (p. 166), regardless of the sex of the therapist. She says that heterosexual men are less likely to have an openly erotic transference, even with a female therapist, ostensibly due to the power dynamics involved—a social concept seconded by Wry and Welles (1994) and by most clinicians in their daily experience. Gabbard (1994) notes another apparent gender difference. He says that male therapists often respond to their female clients' tears with sexual arousal. This may be a power response: a deep show of vulnerability and surrender often elicits sexual feelings in men, but apparently not in women.

Again, I think this has more to do with social roles and expectations than simply the desire to dominate and be aroused by domination. Granted, some male therapists may take sadistic pleasure to the point of arousal in their female clients' suffering. But some may also be simply responding out of the intimacy and tender feelings of the moment. The fact that female therapists are not as likely to feel aroused under the same conditions may have more to do with the fact that the man who is crying is often embarrassed or ashamed, and quite uncomfortable in this position. This self-rejection, combined with the female therapist's own social conditioning regarding what is sexually desirable in a male, may result in the female therapist's tendency not to find this situation arousing.

Pope, Sonne, and Holroyd (1993) have reported that male therapists are more likely to be sexually aroused by a client who is physically attractive, female therapists by male clients who are "successful." So a female therapist may feel great empathy for a man or a woman who is crying, but due to social conditioning is not likely to be sexually aroused.

HETEROSEXUAL ROMANCE AS A DEFENSE AGAINST HOMOSEXUAL FEELINGS

Blum (1973) and Person (1985) note that the intense heterosexual romance within the therapeutic dyad is not always what it appears to be. They argue that sometimes the passionate mutual heterosexual romance is actually a defense against underlying homosexual feelings. In these cases both client and therapist harbor rescue fantasies, conscious or unconscious, that they will finally be able to truly be in love and aroused by someone of the opposite sex—something that has eluded them in spite of their marital status or heterosexual history. The

unavailability of the other helps fuel these unrealistic fantasies, often culminating in open declarations of love that destroy the treatment.

Regarding same-sex pairings, Tyson (1985), Kernberg (1994), Gabbard (1994), and Mann (1997) suggest that social homophobia expectably re-creates itself within the therapeutic situation. Frequently both therapist and client defend against homosexual feelings and fantasies. Male client, male therapist dyads are particularly reluctant to experience homosexual longings. As mentioned previously, Person (1985) and Wry and Welles (1994) note the ease with which women can feel and express erotic feelings toward each other.

The working out of sexual identity conflicts by both therapist and client is a real issue that has not been sufficiently discussed in the literature. Gabbard and Lester (1995) admit that some therapists appear to use their clients to explore their own sexual conflicts and confusion. Citing a study by Benowitz (1995) of therapist–client sex when both are female, they reported that only 40 percent of the female therapists identified themselves as lesbian. The rest identified themselves as heterosexual, bisexual, or confused. Twenty percent had never had sex with a woman before. They also note that Gonsiorek (1989) reported a similar pattern in male therapist–male client dyads. These statistics are remarkable and clearly demonstrate that the therapist who has unresolved issues regarding his or her sexuality is more likely to sexually abuse a same-sex client than a therapist who has self-identified as gay or lesbian.

DISCLOSURE OF EROTIC COUNTERTRANSFERENCE

Most people writing on the subject of erotic countertransference agree that disclosing it is generally not a good idea (Gorkin, 1985, 1987; Mann, 1997). I am really against disclosure of erotic countertransference, with rare exceptions. The verbalization of mutual sexual attraction almost always contains the threat of destroying the therapy relationship. In the normal social context couples reveal their sexual feelings to facilitate either ending or consummating their relationship. Neither of these normal consequences of self-disclosure are applicable to the therapeutic setting.

In *The Power of Countertransference* I cited a case report by Atwood, Stolorow, and Trop (1989) where the client of a supervisee needed her therapist to verbally acknowledge that he found her attractive, having

been denied acknowledgment of her burgeoning womanhood by her father during adolescence. She told him repeatedly that she was not seeking any type of sexual encounter with him. She simply wanted her reality validated. (And she was right, by the way. He was attracted to her.) I cited this as one of the rare instances where I would answer the client's repeated, rational, and well-thought-out request for information of a sexual nature. In line with my guidelines for any disclosure, the client *asked for the information*. The therapist did not volunteer it. I continue to believe that the client who asks the therapist to reveal her attraction toward the client for reality-testing purposes, with no expectations or fears of sex occurring, is the exception rather than the rule.

ACCEPTING THE EROTIC AND LOVING COUNTERTRANSFERENCE

I have stated previously (Maroda, 2002) that the client always knows what we are really feeling, and often it is enough for us not to deny these feelings or to show discomfort when the client accurately identifies our feelings or expresses her own strong feelings. As Kohut (1971) suggested, sometimes it takes great effort simply to sit quietly, fine-tuning our narcissistic equilibrium, as we are told that we are loved beyond words, or found to be beautiful or handsome beyond compare, particularly if we do not feel worthy of such admiration and devotion. Acceptance of the client's feelings lies in the ability to stay with the client, and to stay with our own feelings without undue discomfort. If the therapist feels aroused and then guilty, he is likely to truncate his emotional experience. Furthermore, in the process of distancing himself from his feelings, he necessarily distances himself from the client in that moment.

I must admit that as a mature therapist I infrequently have to deal with any intense sexual transferences. As a young therapist I often faced the romantic and sexual feelings of my clients, perhaps mostly because we were all young and more inclined to be vulnerable, and to welcome romance in our lives. Also, a large number of my clients were unattached.

I was no doubt more seductive than I realized, and so were my clients. As a result of age and experience, as well as clients coming fewer times per week, strong erotic transferences began to disappear from my therapeutic work. Since many of my clients come to me with the knowledge of my reputation and writing, I think they are also reluctant

to express anything that might seem "disrespectful." I have not seen any research on this issue, but I imagine I am not the only older woman who has ceased to inspire strong sexual responses in her clients.

So for the purposes of illustration, I will give an example from earlier in my career. One young woman I treated noticed that she was preoccupied with me and found me sexually attractive. She was married and pregnant with her first child, so she found this experience a bit confusing. She knew that I was a lesbian and wondered out loud if this made it more likely for her to make some kind of erotic connection to me, regardless of her own sexual orientation—a thought that I have pondered many times and find interesting. What bothered her more than anything else was her subsequent realization that I am close to her mother's age. "Does this mean that there were sexual overtones to my relationship with my mother?" she asked. Given that her mother has always been extremely possessive of her and that during her pregnancy her mother announced to a group of friends that her daughter was having "my baby," this hypothesis had potential.

I find the whole notion of the erotic transference–countertransference to be a fascinating one to explore, having been relieved of my guilt and shame for being attracted to my clients, as well as understanding that I need not fear that I will act on those feelings. Even though I agree with Gabbard (1991) when he essentially says, "Never say never," the possibility of my acting on any sexual feelings with a client seems more remote after 25 years of practicing without having done so. I feel certain that I could have done a much better job with erotic transference–countertransference had it been part of my early training. Feeling guilty about my erotic countertransference, and having no introduction to responding constructively to erotic transference–countertransference, made this aspect of therapeutic treatment much harder than it had to be.

Ultimately, each clinician must assess his or her own vulnerability in this arena, as well as his or her strengths. When a client falls in love with the therapist, what does that mean about the therapist's conscious or unconscious wishes? Are some clients, and some therapists, essentially more focused on sexual issues and feelings than others? If so, where does this originate? And what constitutes a good match?

Given the emphasis on mutuality, is it possible for a client to be in love with a therapist who is not at least a little in love with her? Is the therapist's claim of nonparticipation believable, especially in extreme circumstances, such as being stalked, kissed, or finding his client in a state of partial nudity? Are untoward developments in the erotic trans-

ference–countertransference more about power than sexual longing or love? And what is the difference between the therapist encouraging the client to freely express his or her loving and sexual feelings versus establishing an ongoing scenario of sex talk that is sexually gratifying for both therapist and client?

As with everything else I have discussed in this volume, I believe that the progress in therapy, regardless of the issue at hand, can be assessed through a careful reading of the client's responses. Being alert to overstimulating or titillating a client is something that is not often taught, yet is an essential tool for any therapist. Therapists must be equally alert to any interventions causing hurt or humiliation. Therapists who accept their daily mistakes with a sense of acute responsibility while avoiding self-blame and self-flagellations are in the best position to quickly correct these errors.

MUTUALITY AND ASYMMETRY

As a great believer in mutuality, I think that the clients who have loved me or felt sexually attracted to me sensed that these feelings were shared to some extent. The exception I make is the sexually aggressive clients noted by Blum (1973), who typically have a sexualized psychotic transference that includes a defensive illusion that I share their feelings. These clients fear being destroyed by the therapist and seek to protect themselves through sexual conquest.

FACILITATING THE CLIENT'S EXPRESSION

Regarding the expression of sexual feelings, fantasies, and dreams, I encourage my clients to disclose this information if they allude to it or bring it up directly. When these feelings are not a defense against experiencing weakness, dependency, or some other unwanted emotion, then how should healthy expressions of feeling be treated? How does a therapist respond well to a client who asks if she is loved or found attractive? How much expression of eroticism in the therapeutic session is healthy, given that the normal culmination of mutual attraction is not allowed? When are therapists encouraging clients' expressions of adult, sexual relatedness and when are they teasing them or having "virtual" sex in the sessions? Facilitating their self-expression is one thing, engaging in mutual, ongoing seduction is another.

If a client becomes too graphic when discussing sexual matters, I usually try to refocus on what he is feeling. I have never found endless details about a fantasized sexual act to be anything other than a substitute for sex itself. As Bollas (1994) says, "Reporting an erotic fantasy is in some respects an erotic event in its own right" (p. 573). Yet there is no doubt that the tolerance for eroticism can be a highly idiosyncratic trait, depending on the client's and the therapist's views about sex and the body. So how far do you let a client go? How much do you encourage further expression from a client who is prudish and reluctant? I think the level of comfort of both persons is extremely important. If either client or therapist is feeling embarrassment, violation, or sexual overstimulation, this is reason enough to curtail the conversation. Certainly, compatible attitudes about sexuality are aspects of a good therapist–client match. And a sexually restrained therapist may enjoy the contrast between herself and a client who is freer or vice versa. Therapists and clients do not have to be the same, but should be similar enough to reach a comfort level that allows the client to express his sexual feelings, within and outside of therapy, in a healthy, constructive way.

DEALING WITH EROTICISM IN THE TRANSFERENCE–COUNTERTRANSFERENCE

Certainly, sexual and loving feelings can be dealt with better than they have in the past. Interpreting the desire to have sex as nothing more than the child's need to fuse with the mother can be replaced with a more honest and direct acknowledgment of the client's desire to know the therapist physically and to have his or her adult sexuality affirmed. Therapists can become more comfortable with their own sexuality, understanding that they will be attracted to their clients, allowing themselves to have these natural feelings without guilt or shame. Therapists also need to be realistic about their own potential for stimulating sexual feelings in their clients. Those who seem to stimulate their clients too little or too much may choose to examine this issue further in their own treatment.

But in the end the issue of erotic transference–countertransference will always be challenging because of the necessary inhibition of sexual behavior. Responding to the client's erotic feelings is no easy task, as Elise (1991) has pointed out previously. The normal social discourse during such moments must be denied in psychotherapy. Therapists

cannot speak of mutual love or attraction for a client, nor can they reject the client's expressions of unrequited love. So what should they say?

I have found that relaxed and easy exploration on my part puts the client at ease, yet is not seductive. I will ask my client to describe his or her feelings, but never ask for specific sexual details. After all, it is the emotional meaning that is important. As I stated previously, if the client volunteers too much graphic material, I steer him toward feelings instead. I find that the verbalization of this material is very sensitive and I am careful to follow the client's lead regarding when, how much, and in what way we talk about it.

When a client asks how I feel about his or her expressions of love or attraction, I usually say that I am moved, or flattered, or both. I find that most often my clients simply want to know that their feelings are received with understanding and warmth. They want to know that I am neither unreceptive nor overwhelmed.

I recall another client I treated a number of years ago who periodically proclaimed her love for me in a very heartfelt and tender way. I felt touched and saddened when she said how much she wished she could be with me. I just looked at her empathically and said nothing. I literally could not think of one thing to say in that moment that would not diminish the power of her feelings for me, or mine for her. After looking at her for a long time, I finally said, "I don't know what to say right now." She replied, "Just say, 'I know.' " And from that time forward we had an understanding that all I needed to say to her during those moments was —"I know."

SUMMARY

The presence of erotic feelings, often accompanied by love, can serve to open up both therapist and client to an intense, transforming, positive experience. Yet the old warnings about eroticism and proclamations of love as potentially defensive—used to control rather than reveal—must be taken seriously as well. The relational and interpersonal approaches acknowledge that the client, however, is not the only person in the dyad who can use eroticism to derail the treatment rather than deepen it.

Both therapist and client may feel love and attraction for each other for all the best and all the worst reasons. The therapist benefits from examining his or her own behavior and needs, as well as the client's, when the erotic transference–countertransference seems out of control.

Accepting that being loved and desired is gratifying and is often

present at some point in a successful treatment can help therapists to be more comfortable with sexual feelings in the relationship. But acceptance on the therapist's part should not be confused with gratuitous self-disclosure of sexual interest in the client, which is potentially damaging. As with all interventions, the key to knowing what is working and what is not is the client's asymptomatic response to our interventions, along with an ability to move deeper and gain insight.

10

Empowering the Client

The Road to Independence

> There is no golden rule which applies to everyone: every man must find out for himself in what particular fashion he can be saved. All kinds of different factors will operate to direct his choice. It is a question of how much real satisfaction he can expect to get from the external world, how far he is led to make himself independent of it, and, finally, how much strength he feels he has for altering the world to suit his wishes.
>
> —Sigmund Freud, *Civilization and Its Discontents* (1930, p. 83)

This remarkable quote from Freud appears in stark contrast to his theory of psychoanalytic treatment. Clinical psychoanalysis traditionally focused primarily on the individual and his ability to resolve *internal* conflicts and integrate emotions. Yet Freud demonstrates in this essay his acute awareness of the ongoing negotiations between the individual and society. He goes so far as to say that an individual's ability to save himself hinges on his expectations of the world, his ability to move in and out of the larger world, and his ability to influence others. He sees salvation lying not only in self-understanding, but in applying an equal awareness to the outside world, and formulating a way of moving in the world that works.

Civilization and Its Discontents still holds up as an incisive treatise on the individual versus society, noting the inevitable symbiosis and its subsequent demands. Implicit in Freud's words is that knowledge of oneself is insufficient. One must also understand the individuals around him and the culture in which he is embedded.

Sullivan (1953) was an early pioneer in applying social theory to an understanding of individual development. But he did not incorporate his insights into technique. More recently, Wachtel (2007) has stated that individuals not only repeat their past relationships, for better or worse, but they also actively *train* those around them to fulfill their expectations. Wachtel's work is controversial to the extent that he advocates educating clients in treatment about how they are replicating the past, and works to help them understand the personalities and motivations of those around them. I do the same with my clients, provided they are open to this information and are capable of utilizing it productively.

Some clients are eager to improve their awareness of the personalities and possible motivations of important people around them. They will say, "I just don't get it. Why would my husband say something like that to me? Didn't he have any idea how that would make me feel?" At times the answer has as much to do with the client's behaviors as those of the person about whom they wonder. For example, regarding this woman's question about her husband's insensitive remark, further exploration may point to him retaliating for something hurtful she said or being angry at her for ignoring him. These are hypotheticals, of course, but examining the workings of a close relationship necessarily requires a look at each person's possible contributions.

However, not all clients are seeking information about important others in their world. Some find it too personally threatening or feel too guilty discussing the faults and motivations of others close to them. Early in therapy, the client's own painful experiences may fill every session and any comments about others would only be an unwanted distraction. Clients who are focusing on their relationships and needing to understand the important people in their lives will demonstrate this need to know by wondering out loud. From my experience, most clients at some point in therapy seek to understand those around them better. Not infrequently, they are fascinated by the fact that people find each other based on similar early experiences and proceed to re-create their pasts together.

Talking about the client's relationships without falling into the unprofessional arena of diagnosing important persons in the client's life is a delicate issue. Yet if the important relational themes in the client's life are not identified, there is less opportunity for real insight and change.

Taking the risk of making observations about significant others in the client's life requires a fair degree of objectivity and diplomacy on the therapist's part. If the therapist has too negative a reaction to

someone in the client's life, or too positive a reaction, he may be unable to make accurate assessments. Certainly, the observations a therapist makes about the client's relational patterns in both love and work can only be made after extensive listening. Furthermore, any commentary should not deviate too much from what can be discerned from the client's accounts of verbal exchanges with others. Esoteric interpretations that cannot be easily linked to the material being discussed can alienate a client, even if they are accurate. (I almost always ask my clients to provide a blow-by-blow account of any troubling interaction so that I can get a real feel for what actually happened.)

Making assumptions about the character or motivations of others in the client's life certainly has the potential for doing harm. Sticking close to the client's script is most likely to produce a good outcome. What exactly did this person say to him and under what circumstances? How did the client respond, and what was the outcome? Often the interpretation of the relational dynamics by the therapist involves pointing out power struggles and competing needs, or explaining the character of the other person in terms the client can understand.

A good example comes in the case of Christine who, as a girl, was neglected by her mother as she worked long hours with her husband to create a successful business. Christine came to see me when she was in her late 20s. Her parents had worked their way up the socioeconomic ladder, beginning with nothing and becoming multimillionaires. They were generous with their money, but also made Christine work long hours in the business, just as they had at her age. Christine accepted their large monetary gifts at every occasion, but was still hungry for love and acceptance from her mother. She said the money was better than nothing, but she really wanted her mother to be more empathic, warmer, and more accepting of their differences.

Christine had always blamed herself for her mother's intolerance of any difference of opinion and her highly critical and competitive relationship with her. Working on her assertiveness in therapy, she established a more adult-to-adult relationship with her mother and no longer allowed her to control and dominate her. But she still did not have what she wanted. She asked me what she could do to get closer to her mother—to engage her emotionally and really connect with her.

Having heard about years of their interactions, including Christine being more open and vulnerable with her mother, two things became clear to me. One, Christine's mother did love her and would do anything for her. But, having been neglected horribly and mistreated as a young child herself, she simply was not capable of the unguarded

expressions of emotion that Christine craved so deeply. One day, I simply told her this. "There is really nothing you can do. You have done everything possible to establish an open, loving, and respectful relationship with your mother. Yet every time you try to get closer and have a heart-to-heart conversation with her, she flees. I think you are going to have to accept that your mother is too damaged to let anyone break through her defenses—even you. Yet she seems to love you very much."

Christine reluctantly agreed that she had never seen her mother behave any differently with anyone else, including her father. She then began to grieve the reality that she could not change her mother and would therefore never get what she really wanted. She accomplished this over a period of months and finally accepted her mother for who she was.

I don't believe it is that unusual for therapists to make some comments about the motives, feelings, and patterns of behavior of significant others in the client's life. Unfortunately, this represents one of those areas that is rarely talked about because it has never been endorsed (prior to Wachtel, 2007) and must be handled delicately to be effective. If the client appears uninterested or disturbed by this type of discussion, I let it go immediately. For example, in the case of Rebecca, whose parents had abused her emotionally and sexually, she became visibly upset the first time I suggested that they had not functioned well as parents. She also did not want to discuss her passive, masochistic relationship with them. So I stopped. But, over time, I tested the waters when she referenced them in a way that clearly illustrated their shortcomings as parents. She gradually overcame her guilt about finding any fault with them, and her almost paranoid sense that they would know if she criticized them in her sessions and would punish her.

She told me one day that her mother had repeatedly told her that discussing the family with others was the ultimate betrayal. Only a bad person would do that. It took time for Rebecca to become strong enough to overcome these emotional obstacles to both telling me the details of her childhood and being willing to see that her parents had failed her in significant ways, being too mentally ill themselves to fulfill the parent role. Rebecca needed me to move slowly, but steadily, toward a view of her and her parents that was reality-based, but not condemning. One of the things I repeated to her was that I knew she knew the truth about both them and herself. It was a matter of coming to terms with those truths.

People like Rebecca who have had their reality negated from an

early age require patience mixed with the selective injection of reality. They also need a therapist who is self-aware enough to make reasonable distinctions between the client's experience and her own. As Krystal (1988) says:

> It may become necessary for the therapist to challenge the entire material and architecture of the patient's psychic reality in order to be able to free up these early building blocks of the infantile world view. But to chance such a profound shakeup the therapist has to have struggled to reclaim his own soul and be able to name everything in his experience as his own, his self, and his reality. In other words, he has to have exercised his own mental healing powers by extending his selfhood to everything he beholds. (p. 136)

As stated previously, I think Wachtel's (1993, 2007) work reflects this philosophy, going beyond the relationship between therapist and client to include the client's relationships with the outer world. Certainly, newer therapists learn to recognize these patterns of relating over time, either within or outside of the therapy relationship. Early in my career I focused most of my energy on what was going on in the room. As I became more comfortable doing therapy, I was able to look at the larger picture of my client in the world. Making observations about the client's relationships can be done early in therapy, if the therapist feels confident to do so. As with just about everything else in therapy, the client will let you know if he or she is looking for help in the area of understanding others better.

Discussing important people in the client's life requires the freedom that comes with anonymity. With the decline of mental health benefits, many therapists have taken to doing therapy with close associates of their current clients. To my mind, the therapist who is concurrently treating a client *and* his or her spouse or partner; best friend or employer; sibling, parent, or any other close relative or associate, has lost the ability to view the world through the client's eyes. Commenting on the client's close associates, when they are known to the therapist, presents an ethical and clinical dilemma.

Therapists typically do not comment in session on their other clients—for many good reasons. Those who choose to accept referrals of current or past clients' close associates have ethically eliminated those individuals from being discussed in therapy sessions. I have found that if I have even met someone briefly whom a client discusses, I feel uncomfortable commenting in any way about that person's participation in the client's life. I am now burdened with my own thoughts

and feelings about that individual, rather than viewing him or her as an anonymous actor in the client's repetition of the past.

LEARNING TO READ ONESELF AND OTHERS

Living well requires the ability to read both persons and situations accurately, along with an ability to choose when and how to act. Especially in longer-term therapies, the goals of treatment are not just symptom relief, but rather the promotion of self-awareness, an awareness of others and, to some extent, an ability to predict the outcome of one's actions. Clients will vary in their ability to make these assessments in the world, but I have never found anyone to be completely lacking in this regard. Clients feel hopeful as they end therapy when they not only know themselves better, but also better understand their place in the relational world.

That is why I believe it is important to provide feedback to clients about how we see them when they are ready for this information. How else will they learn not only about their internal lives, but also about how they are seen by others? The questions regarding what needs to be accepted as unattainable, versus how to be more assertive and increase interpersonal power and influence, are enduring. Therapists are in the unique position to help their clients with both, working on identifying that which must be grieved and that which requires greater clarity of purpose. Wachtel (1993) speaks of using the therapeutic relationship as a catalyst, "mobilizing and guiding the patient toward taking the actions *in the world* that are necessary for change to be extensive and enduring" (p. 62).

Helping the client develop more assertive behaviors, better impulse control, and better strategies for coping with a variety of interpersonal encounters all fall under this umbrella. Understanding and working within the power dynamics that dominate the workplace may also be on the agenda. Movies and television programs routinely satirize the pathological behaviors expressed in the workplace. The reality for those who are not self-employed is that they must find a "good-enough" match in the workplace, just as they must in their personal lives. Even when the match is a good one, the multiple transference–countertransference, and sibling-competitive relationships in any organization can present daily challenges to even well-adjusted individuals. Why not bring these critical understandings of the role of relationships

in society into psychotherapy, enhancing the client's ability to make his way in the world?

UNDERSTANDING COMPETING NEEDS

Over many years of doing therapy, I have been surprised to see how many people do not understand the basic concept of "competing needs" in relationships. Perhaps the competing-needs scenario goes unrecognized because it is essentially frustrating. A client may feel betrayed, abandoned, or simply alienated from a loved one who is uncharacteristically unsympathetic, emotionally unavailable, or taking a stand that does not include the client's reality. Agreeing to disagree is typically an unsatisfactory conclusion to an emotional encounter, yet it is inevitable in any relationship. I teach my clients that sometimes there simply isn't room at a given moment in time for them to incorporate someone else's reality. Within a marriage or partnership, it can be difficult to accept that one's partner is too needy himself to be emotionally available. However, competing needs do not negate existing love or respect.

Within the therapy relationship, the competing-needs scenario leaves room for unresolved conflict in the moment without the necessity of blame. If I cannot accept my client's perspective on what has happened between us, and she cannot accept mine, I suggest we settle in the moment for agreeing to disagree. We simply see things differently, or have different emotional realities.

The aforementioned case of Nancy serves as an example of someone coming to terms with the concept of competing needs. Recall that Nancy was in the habit of returning home from work in the evening, frustrated from her day of staying in control at work, expecting her husband to comfort her. She literally expected him to be waiting with open arms, offering her solace, empathy, and sympathy. Because it was so difficult for her to suppress her intense emotions during the workday, she felt entitled to "let go" at the end of the day, often expressing frustration or rage and crying uncontrollably. If her husband was not up to the task of providing this expected comfort, Nancy became hysterical and inconsolable.

She told her husband she felt he should understand how difficult life was for her and devote himself completely to her needs when she came home at night. In return, she not only made more money than he

did, she handled the family finances, did most of the grocery shopping, and made all the meals. To her this was a reasonable trade-off. To her husband, of course, it was not.

Originally, if I asked her how she imagined her husband felt, she looked at me with angry disbelief. If I inquired as to *his* state of mind, and what he might need on a given day, Nancy accused me of turning against her and being on her husband's side. She considered this to be a cruel betrayal on my part and treated me accordingly.

It was only after her return to therapy, when she was 50, that she was receptive at all to considering the feelings of others. This was due in part to her greater maturity, in part to having raised her only child and having fewer emotional demands, and in part to my different approach to treating her. She began to accept the idea of competing needs, not primarily due to my references to her husband, but rather as a response to me.

As a highly intelligent person with BPD, Nancy had an uncanny way of reading my emotional state, even when I went to great lengths not to display it. If I was distressed, not feeling well, or preoccupied, Nancy knew it immediately and became agitated and angry. Most of the time she did not consciously know that she was responding to me and it took quite a while for us to figure this out. As mentioned previously in this volume, I finally learned to let her know if I was "off" in some way so that she did not unconsciously sense it and take it as a form of rejection. Instead, we discussed how she felt about me being less available than usual.

At first Nancy had a hard time with anything less than optimal availability from me. She felt she was being cheated. After all, wasn't she paying me the same amount of money? Wasn't she bringing the same level of commitment and pain to her sessions? How could I give less? It was then that I began to teach her about competing needs, noting that as much as I understood her wishes and what might be ideal for her, I was simply human. Sometimes, regardless of what she needed, my own state of neediness kept me from being as emotionally present and engaged. I was sorry, and I understood her disappointment, but it was not something I could control. Eventually, we both began making comparisons to her husband and others in her life who were committed to her, but not always able to respond to her needs. Over time, the notion of two people caring about each other, but each being absorbed in a heightened state of individual need, became something she both understood and accepted. Nancy knew intuitively that she could not be as available to others when she was upset or otherwise self-absorbed,

and began to perceive others not as threatening and rejecting, but simply as having needs that competed with her own.

LOVING AND BECOMING LOVEABLE

For more than a few clients, one of the implicit or even explicit goals of treatment is to become loveable. People who tend to withdraw and avoid engagement, as well as those whose combative behavior drives others away, are keenly aware of the lack of intimacy in their lives. They will often plainly say things like "I don't think anyone really loves me—or knows me." Or "I'm not sure that I really love anyone. I want to. But I'm not sure that I do." Some clients simply need to be less defended and more emotionally available. Others need to develop the capacity to really observe themselves and others, as well as to make significant improvements in their capacity for empathy. Most need to be more emotionally honest, so that they feel confident that any love or admiration they receive is given with the knowledge of who they really are. The difficulty of the task can run from fairly simple to virtually impossible. Nonetheless, people naturally want to love and be loved. And they bring this concern to therapy.

When I first started treating Nancy, it was clear to me that I often liked her, and felt great empathy for her. But I also experienced much frustration and anger. She became the first subject in my countertransference experiments that I described earlier. Telling her I knew she hated me and that I sometimes hated her was enormously difficult, but also enormously therapeutic. Once we had worked through this event, Nancy offered that she loved me and hoped that one day I would love her too, not in the magical, rescuing way that she had originally demanded, but in a real way. She said she knew that even though her husband and daughter loved her, most people did not seem to like her very much. And she did not *feel* loveable. More than anything else, she wanted to be deserving of love—especially mine.

I recall wondering at the time if that would be possible. I have felt love for many of my clients over the years, but I had my doubts about Nancy. She was just so aggressive and demanding; I could not stay close to her or make myself vulnerable enough to feel love for her. As she terminated her first treatment with me, the subject did not come up, and I was relieved. I did not love her when she left the first time and I think she knew it. So she avoided the subject. When she returned 20 years later, the subject of love came up again. Earlier I described some

of the difficult exchanges with Nancy, with me confronting her about her lack of empathy for her husband and her unwillingness to see her role in their arguments. I also continued to give her affective feedback. Our exchanges were more free-flowing than they had been during the previous treatment. I grew to like and admire Nancy more and more. But when she brought up love, I knew I was not there yet. As I am writing this, Nancy has reduced her sessions to once a week, has set a termination date, and is doing extremely well.

Always remaining in the safe bubble of the family, she recently started a book club with a group of women, threw a large party for her husband's birthday, and was promoted at work. For me she serves as an amazing testament to both the plasticity of the human brain and the power of human motivation, in that she developed an observing ego in her 50s. Having worked through her guilt and shame, she now makes jokes about how she can't believe her husband stayed with her all these years, tolerating her unreasonable demands and refusal to take responsibility for her own life. Their relationship is solid and they are looking forward to retiring together. What has most amazed me over the past year is that I have come to love Nancy. And I can see on her face that she knows I do. How do I draw this conclusion? She looks lovingly at me from time to time, without embarrassment or anxiety. She does not avoid seeing my facial expression. In the past she would throw furtive loving looks at me, and then look away. She now exhibits the comfort level that comes with some degree of reciprocity.

Russell (1998) said that "love is the final competence," (p. 36) and that "one is competent only to the extent and to the degree that one can love" (p. 37). In spite of the fact that some of our clients may never achieve this and some have already achieved it when they come for treatment, I cannot argue with Russell's conclusion that the capacity for love is, indeed, the final competence.

IMPROVING RELATIONSHIPS: VARIATIONS ON A THEME

Feeling frustrated and thwarted in relationships is a common problem brought to psychotherapy. Longer-term therapies offer the opportunity to alter established patterns of emoting and relating. I let my clients know that change takes time and practice. Only through trial and error, experiencing failures as well as successes, can a person develop the competence that yields a satisfying relationship.

Helping the client to see himself clearly within the therapy relationship, and to see his therapist just as clearly, strengthens his core sense of self. But what about the client's relationships outside of therapy? How much change is realistic for the client with a history of failed relationships? How can therapy help someone who has not even been successful in creating *bad* relationships? Earlier in this volume I spoke about the ability to form an ongoing attachment as a long-established prognostic indicator. Clients who have not been able to form a long-term relationship previously are far less likely to do so in therapy. For these clients, symptom relief, improved social skills, and the ability to relate in social groups may be more realistic goals.

But most clients are capable of having relationships and are seeking to improve them. I find the most compelling question to be: How can a person who has a track record of bad relationships transcend his or her own history? How does a person go from having self-destructive relationships to nurturing, enhancing relationships? Mitchell (1988) noted that people continue to define love and attachment as what is familiar, and that means repeating relationships established early in life. One of the biggest and most disappointing discoveries I made as a young therapist was that it was impossible to help my clients go from sadomasochistic relationships to nurturing, loving ones. No matter how much they said they wanted a warm, loving relationship, they kept picking people who would be abusive toward them. Just as I was becoming seriously discouraged about my clients' prospects for change, I began to notice something: each new relationship was a little better than the one before it. Therapy seemed to amplify this "experience effect." I began to realize that there was hope even for those clients who had experienced abandonment, neglect, and abuse in their early relationships.

For example, Christine grew up in a symbiotic, yet nonnurturing relationship with her mother, who was critical and intrusive. She saw Christine as a narcissistic object—an extension of herself. Her mother was gregarious and domineering, but Christine was quiet and passive. She married a man who totally dominated her and expected her to serve him like the maids in the wealthy household in which he was raised. When she began saying "No" to any of his demands, or expressed anger at him for doing so little, he became enraged and accused her of not loving him and being disrespectful to him. These dynamics painfully echoed her childhood, where her mother expected her to fill in and make meals and do housework while she and her husband made their fortune.

As Christine began to see both the parallels between her relationship with her mother and that with her husband, she was shocked and dismayed. I also pointed out to her that she had spent years reinforcing her husband's demands and further "training" him to expect her to continue to play the martyr. Discussing the uncanny similarities, she asked me if there was any hope that she could pick someone who *wasn't* like her mother and her husband. (She was planning to divorce her husband and did.)

I said yes and no. The best way to start was by helping her to be more assertive. This took some time due to Christine's low self-esteem. Gradually she came to believe that she had rights too. As she became more assertive, her husband and her mother became angry with her. She was hurt by this, of course, and worried they would abandon here. But I assured her that her mother would not because their attachment was too strong. So she persevered. This was a challenge for her, given that her mother walked away from her and didn't speak to her for a week at a time. But she always came around. Usually she would initiate some social contact and everything would be alright again. Although her mother never acknowledged Christine's feelings, as discussed earlier in this chapter, she began modifying the behaviors that Christine no longer accepted. Her husband, however, could not adapt to her new assertiveness and kept yelling and screaming at her. As I stated earlier, once they had a child and he became even more infantile and demanding, she divorced him.

Once Christine was on her own with her young son, she became much happier and felt more grounded. She continued to be more assertive, including telling her parents that she no longer wanted to work 60 hours a week in the family business. She now had a son, and had paid her dues. She thought a 35- or 40-hour workweek was more reasonable. And they agreed. Christine was slowly altering her way of being in the world, a way that was no longer passive, depressed, and leaning toward martyrdom. She was becoming someone who could no longer participate in the kind of relationship she had once had with her mother and her husband.

Additionally, I encouraged her to be more open with me. She became quite adept at expressing loving feelings toward me, as well as getting angry if she felt I didn't understand something important or had been insensitive to her. Christine was building her sense of self and shedding the victim persona she had developed as a child. She initially came four times a week for therapy, then cut down to twice a week, then to once a week. Having been in symbiotic relationships her whole

life, I knew it was unlikely that she would end her relationship with me until she established a new intimate relationship.

In fact, most of my clients embark on either a new career move or a new relationship prior to terminating treatment. I see this as a natural "moving on" and investment of energy and libido elsewhere. New therapists may have trouble handling this reality at first, being disappointed in no longer being so important to the client. But it speaks to the success of the treatment. And when seen in that light, it becomes a welcome event in spite of any sense of therapist loss.

Christine and I spoke candidly about her prospects as she engaged in online dating. Predictably, it was the outgoing, intelligent men with a strong presence who appealed to her most. She tried dating quiet, gentle men, to see if she couldn't create a new relational pattern. But she inevitably had no sexual interest in these men, no matter how good-looking they were. After a couple of years she found a man who was educated and had sophisticated tastes, as she did. (Her parents were not educated or sophisticated, but they had sent her to good schools, including study abroad.) So they shared interests she did not share with her family.

But he was strong-willed and could be domineering. Interestingly, he had also been in therapy for a few years, and had worked on his tendency to be oversensitive to slights and too selfish. So he was open to Christine expressing her unhappiness when he tried to control her. They fell in love, got married, and had more children together. And Christine ended her long-term therapy with me. I think her situation is a perfect example of finding a variation on her relational theme that worked for her. In spite of all the negative similarities he shared with her mother and ex-husband, her second husband was more liberal, more educated, and matched up far better with her.

Unlike her previous spouse, he was aware of his faults and open to hearing Christine's feelings. He apologized when he was wrong or out of line, and he also gave good feedback to her. They both had found a way to transcend their difficult childhoods and find contentment within a relationship that was not dramatically different from what they knew, but just different enough in all the right places to set it a world apart.

When educating my clients about the process of therapy, I candidly tell them that the changes they make will not be huge—they will not become different persons. (This reality is more often greeted with relief than disappointment. No one really wants to become someone else.) However, even small changes can make for a much more meaningful life.

Christine's second husband and her mother were very much alike. The main differences between them were that he had been in therapy and was able to tolerate knowing his weaknesses instead of having to deny them and blame others. This was what Christine wanted from her mother and couldn't get. She could talk to her husband about their relationship and he showed concern and respect for her feelings. When he acted insensitively and selfishly toward her, as her mother had, he almost always apologized the next day, saying he regretted his behavior and would try harder. That was all she needed from an intimate partner.

DISCUSSING TERMINATION

When my clients ask me how they will know when they are ready to terminate, I tell them a few simple things. First, they may have difficulty finding something meaningful to talk about in their sessions. Second, they are likely to start thinking about what else they could do with the money they pay me. Third, they will notice the power differential between us diminishing. They will no longer feel inferior to me and imagine that everything in my life is better than in theirs. If all goes well, therapy ends not with a bang, but with a whimper. The ending is peaceful, and may even seem anticlimactic. Any drama and high tension that existed in the therapeutic relationship is likely to be a thing of the past. Both therapist and client may feel any combination of relief, satisfaction, and a sense of loss, envy, or even boredom.

The actual use of the word "termination" seems to be declining, especially in light of the fact that many clients come and go from therapy at different points in their lives. When clients ask me if leaving means I consider them permanently finished with therapy—that they cannot return—I assure them this is not the case. As with everything, it is up to them to decide if and when they would ever return for further sessions. Often clients will ask me if others have done this. I say many people do, and many people do not. It all depends on what the future holds. Life crises, unexpected losses, or a new awareness of some problem may motivate clients to return for additional sessions.

I also let clients know that sometimes these returns to treatment may consist of a single session, another longer term of therapy, or something in between. Although most clients seem to need reassurance that it is okay to come back at some point in the future, most of my clients do not. I think what clients are seeking as they are preparing to leave is the

assurance that returning on their own terms is an option. Faced with certain anxieties about leaving, clients want to know the door is not closing and locking behind them. The important point to make, regardless of which way the client is leaning, is that there are no expectations or judgments associated with either leaving permanently or returning at some point in the future.

In *The Power of Countertransference* (Maroda, 1991) I outlined the therapist's countertransference issues affecting termination, including competitiveness, envy, and feelings of loss and abandonment. I also emphasized the idea that every therapy relationship has its limitations and there is inevitable disappointment on both sides when therapy ends. A realistic approach to the end of treatment involves understanding that the relationship necessarily loses steam as the psychological separation evolves. Either therapist or client may fear that this disengagement means their former closeness was an illusion. Rather than doubting the authenticity of the engagement that existed, I think it more helpful to view a certain distance and even an anticlimax as the easiest way to separate. The reduction in the relationship's intensity is not a commentary on what has been so much as a needed segue from dependence on the therapist to autonomy in the world.

Much of the early literature on termination implied that the therapist had a large measure of control over when and how a client ended treatment. I find that my clients end when they want to and for all the best and worst reasons. For example, Carol, a divorced social worker and mother of two children in her mid-40s, began therapy with me because she fell in love with a client and behaved inappropriately. Carol prided herself on her honesty and integrity and felt shame about her actions. Thankful that her supervisor referred her to me, she was greatly relieved by the opportunity to speak about her own life and her countertransference.

Carol announced at the first session that she was ready to do "whatever it took" to resolve her problems, and make sure she did not have any similar lapses in the future. Her clinical supervisor saw that the client in question was referred to another therapist. Carol's tasks were twofold: grieving the loss of her relationship with a male client with whom she had fallen in love, and also focusing on the emotional deprivation in her personal life that set the stage for her overinvolvement.

Carol cried hard at almost every session for several months, grieving that she could not have a relationship with her former client. After about 5 months, when her intense experience of loss began to recede,

issues related to her childhood came up. The more Carol talked, the clearer it became that she had overcome childhood trauma throughout her life by using her high intelligence and steel will to defend herself. She was determined she would not be defeated. Striving to transcend the chaos of her family life, she prided herself on excellent problem-solving skills and the ability to remain cool and calm under duress. Carol prided herself on her self-reliance and capacity for transcending any adversity that she encountered.

Suddenly, she found herself sobbing about her lost childhood. She told me she was overcome with sadness in her sessions, and for a whole day afterward felt vulnerable and anxious. She didn't particularly like the experience. I asked her if she realized this meant her defenses were lessened and she was getting to her buried feelings. Carol said she realized she was regressing and that the sadness and anxiety she felt had always been there. She knew this was what she said she wanted to do in therapy. But now that she was actually experiencing it, she wasn't so sure. We discussed the process for a couple of sessions and, as we did so, Carol became more critical of me and the process. Even though she was partially aware that the new defensiveness she was feeling was in response to her deep pain, Carol could not overcome it.

She expressed skepticism about whether letting down her defenses was really therapeutic, and she finally said that she hated feeling weak and vulnerable. She liked feeling strong and knowing she could conquer any problem. No amount of encouragement or empathy on my part changed her mind, and she terminated her treatment.

Carol is an excellent example of someone who understood the therapeutic process intellectually, but once she was immersed in it decided that this was not what she wanted. She was pleased that the early phase of treatment helped her achieve significant symptom relief and feel more in control. When the therapy took a different turn, Carol ceased to see therapy as beneficial and saw it more as a process that had the potential for destroying her. Carol was still functioning perfectly well and did not exhibit any of the symptoms of a nontherapeutic regression outlined in Chapter Three. Her regression was therapeutic. I worked to control how deep I went with her because I could see the underlying vulnerability in her. Nontherapeutic regression was definitely a possibility in her case, and she intuitively understood, and feared, her potential for that experience.

Carol's fears ultimately prevailed when she chose termination. My desire to continue her treatment, which I believe she needed to avert further countertransference difficulties with clients, was really inconse-

quential. I had no power to persuade Carol to remain in therapy even though she had had a good experience with me and respected me. Carol did what she felt she needed to do to preserve herself. Perhaps she was right. Or perhaps she simply did not want to feel out of control in an asymmetrical relationship. In either event, the decision about whether to stay or leave was hers to make. Empowerment in shorter-term treatments means respecting and honoring the client's decision to end, even if it is one we do not agree with.

SUMMARY

Whether short term or long term, the goal of therapy ideally involves a measure of giving over to the therapeutic process, followed not only by symptom relief but by empowerment. Especially in longer therapies, the client benefits from receiving feedback about himself and his relationships. Situating himself in the larger world of relationships and society facilitates a stronger sense of self and enhances the client's ability to successfully navigate in the world. Growing in awareness of the impact of his behavior on others, of the impact that others have on him, and of how people in relationships train each other to repeat both positive and negative past ways of relating builds the client's confidence in assessing life situations accurately.

Even the closest love relationships necessarily involve some disappointments and periods where competing needs preclude the desired emotional availability of the other. Understanding what is realistic and what is not can help prevent unnecessary self-blame or blaming of others when disappointments occur. The capacity to give and receive mature love is a developmental achievement, not a given. Yet it is also essential for emotional stability and self-esteem. Early experience is the best predictor of adult relationships, but even clients who experience neglect and trauma can work to find a variation on their relational theme that allows for love and respect.

The course of therapy varies, depending on the goals set by client and therapist, and on their respective capacities. Shorter-term therapies typically focus on symptom relief and stabilization. The client is relieved to feel comfortable again and leaves without too much difficulty. Even if the client could benefit from further therapy, that decision must be made, and embraced, by the client in order for further treatment to take place and be productive.

The final phase of a longer-term therapy focuses on consolidat-

ing and integrating the accomplishments throughout the therapy. Old issues are often revisited for a final working through. The client looks to the therapist to acknowledge her progress and hard work, which is a vitally important part of empowering the client. The client declares her independence by showing she can fend for herself, including finding relationships and activities outside the treatment that now are the primary focus of her life. As the discussion of a final meeting takes place, both parties feel the bittersweet nature of ending, yet are imbued with the hope of continued growth and change.

Conclusion

Although this volume has come to an end, I am acutely aware of what remains to be accomplished. Providing clinical guidelines for a psychodynamic approach is not the task of one person, but rather the task of all who practice and write. I believe we are obligated to pass our expertise on to the next generation, even though this is not easily done. Our obligation to produce clinicians who know how to help the troubled clients who come to them weighs heavily on our shoulders. We do not want to encumber them with rigid rules that prevent the very emotional engagement we know is needed for success. Yet we do not want to send them out unprepared for the intense emotional encounters with clients that they will inevitably experience.

Those who wish to stimulate the creative use of intuition in their students may believe that even the most basic guidelines will stifle that creativity. But I have not found this to be true. Rather, providing some clinical guidance rooted in theory and research serves to ground the new therapists, giving them the confidence they need to engage their clients. As valuable as didactic learning and individual supervision can be, they cannot compensate for the lack of general clinical guidelines that are essential for providing a reasonable standard of care.

I look forward to being a part of what I hope will be a growing literature on affect, attachment, and specific clinical interventions, like self-disclosure, noting who tends to benefit more and who less. Good intuition may be a predictor of who will be an outstanding clinician, but the research to date says that experience, followed by level of training, are the best indicators, regardless of theoretical orientation. What

does that tell us? Does it mean that it doesn't matter what approach you use, as long as you've spent some time working with people and studying? Most of us find that hard to believe, yet have no answer to the question "How can we account for this?" Psychodynamic clinicians don't appear to be better at doing therapy than other clinicians, even when they have postdoctoral analytic training.

Based on this evidence, we could conclude that the therapeutic relationship is not only central to outcome, it is the only really important factor, and one that cannot be impacted by formal training. But I am not prepared to come to that conclusion, even though I firmly believe in the value of a strong therapeutic alliance. Instead, I believe that no school of thought has adequately provided new therapists with clinical guidelines for both surface and depth work. The result is what I have stated previously in this volume: therapists essentially are trained on the job, by their clients. If we are open to examining the results of our interventions, both immediate and long term, we can build a reasonable set of clinical guidelines and do the research to prove that they work.

I invite new therapists to discover what is really helpful, and what may not be as helpful, regarding the guidelines I have laid down here. One of the guiding principles of the recommendations I make is that each therapist must find his or her own way, and any advice or recommendations have the potential for failing. I am also aware that clinical guidelines are necessarily both culture-bound and generation-bound. Even if basic guidelines are universal, they need to be stated and implemented in the language and style of the time. In that spirit, I invite the reader to consider what I have to say, use it wisely, and feel free to discard what cannot be used productively. Feel free too to break out of the structure that I provide and redefine concepts that work from your own frame of reference. I also encourage you to record your everyday successes and failures, and make the effort to publicly share those experiences with colleagues. Creating a body of useful psychodynamic techniques is not beyond our imagination or our capabilities.

Glossary

Acting out—A dated term that is highly subjective in its definition, especially as it is applied to clients on a day-to-day basis. It refers to any conflict, stimulated feelings, or thoughts that are expressed through overt behavior other than verbalization. For example, a client is said to be "acting out" if he is angry and expresses it by being late for a session rather than expressing his anger verbally.

Affect—This term is broadly defined as the experience of feeling or emotion. Sustained affective states are sometimes referred to as "moods."

Affect regulation—The ability to experience, name, and constructively express affects or emotions.

Affective communication—Specifically, communication that is primarily an expression of emotion. Affective communication may be done consciously or unconsciously.

Alexithymia—The relative lack of ability to express any significant emotion other than anger.

Anxious attachment—One of the basic attachment styles as defined by John Bowlby (1977). This type of attachment results from unpredictable caregivers, who do not provide a consistent, secure environment of emotional availability. Persons with anxious attachment are prone to separation anxiety and dependency.

Confirmatory responses—The client's positive expression following the therapist's intervention, as defined by Langs (1974) in this text. Even a positive reference to something or someone else following a specific intervention, or a

particular session, suggests that the therapist's responses have been beneficial to the client.

Conscious—Refers to experience that is in awareness at a specific moment, for example, thoughts and feelings, including the recall of past experience.

Contagion factor of emotion—This refers to the fact that human beings are naturally empathic, presumably as part of a socially based survival mechanism. For example, if a person in a group shows fear, others will register that fear not only cognitively, but also emotionally. The register of the other's emotion would make the others more likely to look for, and respond to, danger.

Countertransference—This term has been redefined repeatedly for many decades. But for the purposes of this text, it refers to all of the therapist's emotional reactions to the client.

Display rules—These are the cultural and social norms and expectations regarding the expression of emotion, which effects not only verbal expressions, but also facial ones. Display rules exist within every culture, but may vary on the basis of socioeconomic group, ethnic group, and intrafamily personal preferences or personality style.

Dissociation—A lack of connection between thoughts, emotions, and memories, often caused by trauma. The client who dissociates for more than a moment within a session usually has a glazed look and is silent.

Dyadic effect—A term used to describe the fact that self-disclosure from an individual tends to stimulate self-disclosure in the person he or she is talking with.

Ego functioning—This term has its roots in Freud's early topology of id, ego, and superego. Broadly speaking, ego functions are those that suppress sexual and aggressive impulses and help both defend and regulate the individual constructively. Coping mechanisms and affect regulation are both ego functions, as are the ability to assess reality and execute decisions. Those who manage themselves and situations well are said to have "good ego strength."

Emotional annihilation—Rather than an actual event, emotional annihilation most often refers to a primitive fear that may arise in therapy, due to early experiences of being abandoned, traumatized, or negated. The client may express that he or she fears being destroyed or killed by the therapist.

Emotional storms (affect storms)—Unexplained extreme emotional outbursts, usually involving anger and/or fear, that are often stimulated unconsciously.

Most frequently seen in clients with borderline personality disorder, emotional or affective storms render the client impermeable to reason and may be difficult for both client and therapist to manage.

Enactment—Similar to acting out, enactment involves repeating some scenario from the past within therapy, without conscious knowledge or intent.

Erotic countertransference—The therapist's sexual feelings toward the client.

Erotic horror and erotic terror—These two terms are similar, the former having been utilized by Wry and Welles (1994) and the latter by Kumin (1985). Both terms generally refer to the client's fear of becoming hopelessly dependent and potentially experiencing emotional annihilation within the context of sexual feelings toward the therapist.

Erotic transference—The client's sexual feelings toward the therapist.

Erotized transference—A term coined by Blum (1973) to describe a defensive, power-driven, erotic interest in the therapist that is aggressive and angry rather than loving.

Grandiosity—An exaggerated sense of importance and/or abilities, often the result of being both overvalued and demeaned during childhood. It is observed particularly in clients with narcissistic personality disorder and bipolar disorder. Heinz Kohut (1971) wrote extensively about grandiosity with regard to narcissistic development.

Homeostasis—A term borrowed from biology that refers to the organism's tendency to maintain a steady internal condition. It is associated with stability and identity. Change is difficult for most people, in part because it disturbs their homeostasis, no matter how unadaptive that might be.

Kindling—A reexperiencing of intense emotions associated with early trauma. The endorphin high resulting from this emotional experience can become "addictive" in the sense that it is its own odd form of pleasure that may be sought out repeatedly for this purpose.

Labile—Emotional equilibrium is desirable for stable functioning. Lability refers to wide and unpredictable swings in emotion that the individual has little control over and that are by nature destabilizing.

Lull—Refers to periods in therapy where the client feels lost and does not know what issue to take up next. He or she may ask the therapist for guidance, whether or not the client is defending against facing a difficult issue or is simply in transition and unsure of what to talk about.

Malignant narcissism—Not an official part of psychodynamic terminology, it is a colorful phrase that is used to describe those individuals who chronically disregard the feelings and needs of others, with little or no guilt or motivation to change, no matter how much others are hurt.

Masochistic submission—Seen in both therapists and clients, masochistic submission is the passive acceptance of angry, sadistic behaviors of another.

Mutual influence—An aspect of the more general theory of mutuality, mutual influence refers to the natural tendency of both people in a relationship to desire to affect each other in certain ways, and for this influence to occur. That is why it behooves therapists to be self-aware regarding what they may want or need from their clients, because influence is inevitable.

Mutual resistance—The counterpoint to mutual influence, mutual resistance is the companion natural tendency to resist both being influenced and known by another.

Narcissistic equilibrium—The state of being reasonably stable and able to withstand the hurts and disappointments of life. When an individual is uncharacteristically insecure, for example, it may be said that his narcissistic equilibrium has been disturbed.

Narcissistic injury—A blow to an individual's self-esteem. Some people are easily injured, and therefore said to be "narcissistically vulnerable." But anyone can experience narcissistic injury if the hurt is significant enough, such as when being rejected by an important person or losing a long-time job.

Narcissistic vulnerability—The tendency to be easily hurt, offended, or humiliated by other people or by failure.

Nonconfirmatory responses—A negative response by a client to some intervention by the therapist. These may include negative references to others or to events outside the treatment.

Observing ego—The capacity to realistically observe oneself, including both strengths and weaknesses. Necessary for taking responsibility for one's behavior.

Oedipal winner—A colloquial term for someone who has been the main love object for a parent, with some romantic or incestuous overtones. The term "double Oedipal winner" has been used to describe individuals who become the love objects for both parents—often, but not always, an only child.

Personal analysis—The therapist's own participation in psychoanalysis. Freud believed that in order to be a good analyst, personal analysis was essential.

Projective identification—This term is probably one of the most misused and least understood in psychoanalysis. It has been out of vogue for some time because of the tendency for therapists to attribute any criticism by the client to "projective identification," meaning that the client is projecting negative characteristics onto the therapist that are not justified. More recently, the term has been used to explain that intense, disavowed affects may be communicated unconsciously by the client and received, consciously or unconsciously, by the therapist. This communication may also be done in reverse, with the therapist unconsciously communicating some disavowed affect to the client.

Psychosomatic reactions—Physical symptoms or even temporary "illnesses" that result from the experience of unmanageable emotions. It is unknown why some people tend to "somatize," meaning their emotional distress quickly becomes physical distress, often without any accompanying insight.

Regression—The breaking down of defenses, necessary for any significant emotional change, often accompanied by anxiety and confusion as well as positive feelings toward the therapist. When occurring in clients with insecure attachment, there may be a period marked by intense separation anxiety and feelings of dependence.

Sadomasochistic reenactments—The reexperiencing in the therapy relationship of sadomasochistic events from the past. A therapist who is aggressive, passive–aggressive, or passively placating and overly solicitous is likely to be participating in a sadomasochistic enactment.

Self-disclosure—The verbal expression of emotion, personal information, or observations about others, including the client. It may be deliberate or inadvertent.

Surrender—The process of giving over to the experience of one's own deep emotions.

Transference—The repetition of past patterns of feeling, thinking, and behaving in the present, especially in the therapy relationship.

Unconscious—Initially thought to be a separate entity from consciousness, neuroscience research suggests that consciousness is both in flux and on a continuum. Cognitive and emotional experience may be shunted from conscious awareness to outside of conscious awareness either to defend against painful experience or to create room for new experience.

Unconscious to unconscious communication—The communication of affect between two individuals without either being consciously aware of it. The result may be one of being overcome unexpectedly by some emotion, or may

be a visceral reaction, such as gastrointestinal distress or noises. (See **projective identification**.)

Unformulated experience—A concept created by Donnel Stern (1997) based on his observations that clients could defend against "knowing" and feeling past painful experiences, rather than repressing them. Therefore, the objective of therapy is the surfacing and formulation of formerly unclarified and diffuse experience. It is the creation of meaning.

Unformulated technique—A term I have created to describe the basis for clinical judgments made by experienced therapists who claim not to have adopted any clinical guidelines. I believe they have essentially been recording, albeit unconsciously, the results of their interventions with clients, and retrieve that information without necessarily having any conscious awareness of doing so.

Vicarious traumatization—The process whereby the therapist (or anyone else), as a result of empathically listening to a client's reliving of a traumatic event, shares to some degree the experience of being affectively overstimulated and overwhelmed.

Annotated Bibliography

The following is a list of books that I have read and found valuable for clinical work. I have tied them to the topics presented in this book for those who would like to read further than the limited literature reviews provided in this text. They are grouped along general themes, but each is unique in its perspective. I have listed theoretical and philosophical works as well as clinical ones because I believe strong clinicians are grounded in both theory and practice.

PSYCHODYNAMIC CLINICAL WORKS

Bacal, H. A. (Ed.). (1998). *Optimal responsiveness: How therapists heal their patients.* Lanham, MD: Aronson.

This is an edited volume, and is uneven as most are, but offers some excellent chapters, primarily the ones written by Bacal individually and coauthored with others. Unique in its ability to add significantly to the self-psychology perspective established before Kohut's death.

Basch, M. (1990). *Doing psychotherapy.* New York: Basic Books.

A good primer that offers practical information and insight into the clinical process.

Casement, P. (1985). *Learning from the patient.* New York: Guilford Press.

A modern classic, this book was one of the first to emphasize the importance of deep, empathic listening, with a nonauthoritarian approach to working closely with the client. Highly recommended.

Hedges, L. (1983). *Listening perspectives in psychotherapy.* Northvale, NJ: Aronson.

A book that never seems to become dated, this volume addresses the need for empathy and flexibility in listening to individual clients. Intellectual while still being readable. An excellent basic text.

McWilliams, N. (1994). *Psychoanalytic diagnosis.* New York: Guilford Press.

This book has become a classic and is used internationally to train therapists to assess their clients in deeper, more meaningful ways than are possible with the DSM-IV. It is about understanding what makes people who they are, rather than simply labeling their pathology. An invaluable resource.

McWilliams, N. (1999). *Psychoanalytic case formulation.* New York: Guilford Press.

Provides a wide range of case examples illustrating the use of psychoanalytic diagnosis. Also a best-seller and widely adopted internationally.

McWilliams, N. (2004). *Psychoanalytic psychotherapy.* New York: Guilford Press.

Provides valuable guidance to beginning therapists about conducting a psychodynamic treatment. As in all of her books, McWilliams's clinical wisdom and even-handed attitude shine through.

Safran, J. & Muran, J. C. (2002). *Negotiating the therapeutic alliance.* New York: Guilford Press.

In their popular book used frequently as a text, authors Safran and Muran offer insight and instruction on the vital role of "rupture and repair" in the therapeutic relationship, as well as discuss other aspects of building a good therapeutic relationship. A good read.

Wachtel, P. (1993). *Therapeutic communication: Knowing what to say when.* New York: Guilford Press.

Wachtel, P. (2007). *Relational theory and the practice of psychotherapy.* New York: Guilford Press.

These two books by Paul Wachtel (who is claimed as one of their own by both behaviorists and psychodynamic clinicians alike) offer excellent clinical insights and guidance. In his most recent text, Wachtel situates his approach within the relational context. Both are very readable and speak to clinicians as few do.

BOOKS ON BOUNDARIES

Celenza, A. (2007). *Sexual boundary violations: Therapeutic, supervisory and academic contexts.* Lanham, MD: Aronson.

This book has it all: research on who commits sexual boundary violations, who is more likely to be a victim, and what emotional and social conditions contribute to these events. Compassionate toward both victim and transgressor, along with providing guidelines for prevention, this book is a must read for all clinicians. Very readable.

Gabbard, G., & Lester, E. (1995). *Boundaries and boundary violations in psychoanalysis.* New York: Basic Books.

Gabbard and Lester provide a basic overview that is highly readable and covers all the major bases. Should be read by every therapist.

Pope, S., Sonne, J., & Holroyd, J. (1993). *Sexual feelings in psychotherapy.* Washington, DC: American Psychological Association.

Although focused mostly on avoiding sexual encounters with clients, the book is also a good primer on boundaries. What a therapist does to avoid physical intimacy is often just good sense about boundary keeping in general.

BOOKS ON BORDERLINE PERSONALITY DISORDERS

Gabbard, G., & Wilkinson, S. (1994). *Management of countertransference with borderline patients.* Washington, DC: American Psychiatric Press.

As with all of Gabbard's books, this one is highly informative and readable. Another basic text that should be in every clinician's library.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism.* New York: Aronson.

Requires some basic knowledge of psychoanalytic terms. An analytic classic, filled with great clinical observations, but written during a time when blaming the client was considered acceptable. Read it for clinical insight, but remember that clients with these diagnoses have strengths and favorable characteristics too.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Even though I am psychoanalytic, Linehan must be given her due, particularly with regard to managing affect in clients with BPD. Integrated with

affect theory and psychodynamic theory, her behavioral interventions can be very effective.

Masterson, J. (1976). *Psychotherapy and the borderline adult.* New York: Brunner/Mazel.

During the late 1960s and 70s the literature on separation-individuation was extremely popular and diagnoses were often formulated with this developmental line at the forefront. Although today general attachment, genetic predisposition, affect management, and overall environmental factors are considered more important than the separation-individuation phase, this book nonetheless contains much useful clinical material and insight.

CLASSIC PSYCHOANALYTIC WORKS

Reading these works requires a working knowledge of psychoanalytic theory and jargon. But they are classics for a reason, and the ones listed below are all reasonably accessible.

Balint, M. (1968). *The basic fault.* London: Tavistock.

This volume describes the inner world of clients whose early psychological development was disturbed by loss, trauma, or inadequate caretaking. Contains the discussion of regression referred to in this text. Demonstrates the depth of psychoanalytic thought and observation. Invaluable for working with difficult clients who talk about their sense of being empty inside or falling into a black hole. This is what Balint refers to as an awareness of the "basic fault."

Fromm-Reichmann, F. (1950). *Principles of intensive psychotherapy.* Chicago: University of Chicago Press.

This classic text may seem very dated to young therapists, but it offers insights and a positive attitude about working with difficult clients hard to find elsewhere. Worth the effort to bridge the generational divide for those convinced of the value of the psychoanalytic approach.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis.* New York: International Universities' Press.

Greenson became famous for treating Marilyn Monroe, but he suffered a loss of reputation in some circles after she died of a drug overdose. Though his clients were the rich and famous of Beverly Hills, Greenson was a serious psychoanalyst who was ahead of his time in acknowledging the client's experience as more than "transference." He was one of the first to talk about the "real relationship" between therapist and client and gives solid advice to those with a psychoanalytic orientation.

Langs, R. (1973). *The technique of psychoanalytic psychotherapy, volume 1.* New York: Aronson.

Langs, R. (1974). *The technique of psychoanalytic psychotherapy, volume 2.* New York: Aronson.

This two-volume set is filled with case examples and great wisdom. Langs provides details about everyday aspects of practice, including office setting and fees; what it means when the client arrives late; and how to understand and respond to the client's deep feelings. It has everything, which is its greatest strength and its greatest weakness. It could have been edited down to one volume and been more accessible. Reading this set requires dedication, and Langs's focus on almost rigid boundaries, including avoidance of any self-disclosure, dates the books somewhat. Nonetheless, the reader who perseveres will be rewarded.

Langs, R. (1978). *The listening process.* New York: Aronson.

Again, this book is many times longer than it should have been. Yet it contains Langs's classic discussion of latent and manifest meaning in the client's material. As with all his work, and in line with the time when he wrote these books, his perspective is a bit authoritarian and does not involve, or even condone, any collaborative effort with the client. But once you have read his descriptions and case examples of how clients express their hidden thoughts and feelings, you will never listen to your clients the same way again. Langs is one of the few authors who provides too many case examples, and one gets the feeling when reading his major works that they may have been dictated rather than written out. Unfortunately, this volume is out of print, but can be bought used at Amazon.com.

Levenson, E. A. (1972). *The fallacy of understanding: An inquiry into the changing structure of psychoanalysis.* New York: Basic Books.

An early analytic text written by a master psychoanalyst who was perhaps the first clinician to argue for the therapeutic value of "failing" the client and admitting to failure and weakness in the pursuit of confirming the client's reality and encouraging his autonomy. Few clinicians can match Levenson for depth and wisdom.

PHILOSOPHICAL AND CLINICAL MUSINGS ON THE THERAPEUTIC PROCESS

There are books that give good practical advice about treating clients, and there are books that allow the reader to inhabit the mind and heart of a dedicated therapist. I have found both types to inspire me as a clinician and am therefore recommending the following books.

Buechler, S. (2004). *Clinical values: Emotions that guide psychoanalytic treatment.* Hillsdale, NJ: Analytic Press.

Buechler speaks about her experiences doing psychoanalytic treatment from the perspective of the intense affects that permeate the therapeutic relationship. She is passionate and articulate in describing her intense encounters with patients who needed her to be not only intellectually aware, but emotionally present. A persuasive argument for being more aware of the centrality of affect.

Charles, M. (2004). *Learning from experience.* Hillsdale, NJ: Analytic Press.

This author is one of the best writers in psychoanalysis. She is deeply philosophical and is not afraid to embrace big ideas. This treatise on her experience as a therapist can be appreciated by all therapists, regardless of their theoretical orientation.

Hirsch, I. (2008). *Coasting in the countertransference.* Hillsdale, NJ: Analytic Press.

Irwin Hirsch created quite a stir with this rather confessional, but courageous, narrative about how he and most other therapists he knows tend to serve their own needs while being therapists, particularly their financial needs. He discusses keeping patients too long, avoiding conflict with them so they won't leave, and seeing so many patients that some of them inevitably are seriously short-changed as typical self-serving therapist behaviors. Not for the faint of heart, but hits the mark.

Rako, S., Mazer, H., & Semrad, E. V. (1980). *The heart of a therapist.* New York: Aronson.

This volume was created after Semrad's death by colleagues and students who had written down or remembered some of his reflections on the clinical process. He was a beloved teacher and supervisor who did not record his clinical wisdom. Rako and Mazer put together these pages, which are not a book per se, but rather pages of interesting observations and aphorisms from Semrad. Humanistic, with an emphasis on caring about the people you treat.

References

Altman, M. (1995). Vicissitudes of the erotized transference: The impact of aggression. *Psychoanalytic Review, 82,* 65–79.

Andersen, S. M., Reznik, I., & Glassman, N. S. (2005). The unconscious relational self. In R. Hassin, J. Uleman, & J. Bargh (Eds.), *The new unconscious* (pp. 421–481). New York: Oxford University Press.

Arlow, J. A. (1979). Metaphor and the psychoanalytic situation. *Psychoanalytic Quarterly, 48*(3), 363–385.

Aron, L., & Bushra, A. (1998). A. Mutual regression: Altered states in the psychoanalytic situation. *Journal of the American Psychoanalytic Association, 46*(2), 389–412.

Aron, L., & Harris, A. (Eds.). (2005). *Relational psychoanalysis: Innovation and expansion* (Vol. 2). Mahwah, NJ: Analytic Press.

Atwood, G., Stolorow, R., & Trop, J. (1989). Impasses in psychoanalytic therapy: A royal road. *Contemporary Psychoanalysis, 25,* 554–573.

Bacal, H. A. (Ed.). (1998). *Optimal responsiveness: How therapists heal their patients.* Lanham, MD: Jason Aronson.

Balint, M. (1968). *The basic fault.* London: Tavistock.

Bargh, J. A., Chaiken, S., Govender, R., & Pratto, F. (1992). The generality of the automatic attitude activation effect. *Journal of Personality and Social Psychology, 62*(6), 893–912.

Barrett, M. S., Wee-Jhong, C., Crits-Cristoph, P., & Gibbons, M. B. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training, 45*(2), 247–267.

Basch, M. (1991). The significance of a theory of affect for psychoanalytic technique. *Journal of the American Psychoanalytic Association, 39S,* 291–304.

Benowitz, M. S. (1995). Comparing the experiences of women clients sexually exploited by female versus male psychotherapists. In J. Gonsiorek (Ed.), *Breach of trust* (pp. 213–244). Thousand Oaks, CA: Sage.

Bion, W. R. (2003). A theory of thinking. In J. Raphael-Leff (Ed.), *Parent–infant psychodynamics: Wild things, mirrors and ghosts* (pp. 74–82). Philadelphia: Whurr.

Bird, B. (1972). Notes on transference: Universal phenomenon and hardest part of analysis. *Journal of the American Psychoanalytic Association, 20,* 267–301.

Blum, H. (1973). The concept of eroticized transference. *Journal of the American Psychoanalytic Association, 19*, 41–53.

Bollas, C. (1994). Aspects of the erotic transference. *Psychoanalytic Inquiry, 14,* 572–590.

Borbely, A. F. (1998). A psychoanalytic concept of metaphor. *International Journal of Psycho-Analysis, 79*(5), 572–590.

Bowlby, J. (1977). The making and breaking of affectional bonds: I. Aetiology and psychopathology in the light of attachment theory. *British Journal of Psychiatry*, *130*, 201–221.

Bridges, N. (1995). Managing erotic and loving feelings in therapeutic relationships: A model course. *Journal of Psychotherapy Practice and Research, 4,* 329–339.

Bridges, N. (2005). *Moving beyond the comfort zone in psychotherapy.* New York: Jason Aronson.

Bucci, W. (2002). From subsymbolic to symbolic—and back: Therapeutic impact of the referential process. In R. Lasky (Ed.), *Symbolization and desymbolization: Essays in honor of Norbert Freedman* (pp. 50–74). New York: Other Press.

Buechler, S. (2008). *Making a difference in patients' lives: Emotional experience in the therapeutic setting.* New York: Routledge.

Casement, P. (1985). *Learning from the patient.* New York: Guilford Press.

Celenza, A. (1998). Precursors to therapist sexual misconduct: Preliminary findings. *Psychoanalytic Psychology, 15*(3), 378–395.

Celenza, A. (2003). Analysts who commit sexual boundary violations: A lost cause? *Journal of the American Psychoanalytic Association, 51*(2), 617–636.

Celenza, A. (2007). *Sexual boundary violations: Therapeutic, supervisory, and academic contexts.* Lanham, MD: Jason Aronson.

Clore, G. C. (1994). Why emotions are felt. In P. Ekman & R. J. Davidson (Eds.), *The nature of emotion* (pp. 103–111). New York: Oxford University Press.

Coen, S. (1994). Barriers to love between patient and analyst. *Journal of the American Psychoanalytic Association, 42*, 1107–1135.

Coen, S. (1996). Love between therapist and patient: A review. *American Journal of Psychotherapy, 50*, 14–27.

Coen, S. (2000). The wish to regress in patient and analyst. *Journal of the American Psychoanalytic Association, 48*(3), 785–810.

Curtis, R. (2004). What 75 psychoanalysts found helpful and hurtful in their own analyses. *Psychoanalytic Psychology, 21*(2), 183–202.

Dalenberg, C. (2004). Maintaining the safe and effective therapeutic relationship in the context of distrust and anger: Countertransference and complex trauma. *Psychotherapy: Theory, Research, Practice, Training*, *41*(4), 438–447.

Darwin, C. (1998). *The expression of the emotions in man and animals* (3rd ed.;

Introduction, Afterword, and Commentaries by Paul Ekman). New York: Oxford University Press.

Davidson, R. J. (1994). Honoring biology in the study of affective style. In P. Ekman & R. J. Davidson (Eds.), *The nature of emotion* (pp. 321–328). New York: Oxford University Press.

Davis, T. (2002). Countertransference temptation and the use of self–disclosure by psychotherapists in training: A discussion for beginning psychotherapists and their supervisors. *Psychoanalytic Psychology, 19*(3), 435–454.

Dimberg, U., Thunberg, M., & Elmehed, K. (2000). Unconscious facial reactions to emotional facial expressions. *Psychological Science, 11,* 86–89.

Dunn, J. (1994). Experience and understanding of emotions, relationships, and membership in a particular culture. In P. Ekman & R. J. Davidson (Eds.), *The nature of emotion* (pp. 352–355). New York: Oxford University Press.

Ehrenberg, D. (1982). Psychoanalytic engagement—The transaction as primary data. *Contemporary Psychoanalysis*, *18,* 535–555.

Ehrenberg, D. (1992). *The intimate edge.* New York: Norton.

Ekman, P. (1971). Universal and cultural differences in facial expressions of emotion. In J. K. Cole (Ed.), *Nebraska Symposium on Motivation: Vol. 4* (pp. 207–283). Lincoln: University of Nebraska Press.

Elise, D. (1991). When sexual and romantic feelings permeate the therapeutic relationship. In C. Silverstein (Ed.), *Gays, lesbians, and their therapists* (pp. 52–67). New York: Norton.

Epstein, L. (1979). The therapeutic function of hate in the countertransference. In L. Epstein & A. Feiner (Eds.), *Countertransference* (pp. 213–234). Northvale, NJ: Aronson.

Epstein, L. (1995). Self-disclosure and analytic space: Some issues raised by Jan Greenberg's paper on self-disclosure. *Contemporary Psychoanalysis, 31*(2), 229–236.

Farber, B. A., Berano, K. C., & Capobianco, J. A. (2004). Clients' perceptions of the process and consequences of self-disclosure in psychotherapy. *Journal of Counseling Psychology, 51*(3), 340–346.

Fazio, R. J. H. (1986). How do attitudes guide behavior? In R. M. Sorrentino & E. T. Higgins (Eds.), *Handbook of motivation and cognition: Foundations of social behavior* (pp. 204–243). New York: Guilford Press.

Ferenczi, S. (1932). *The clinical diary of Sandor Ferenczi* (J. DuPont, Ed.; M. Balint & N. Z. Jackson, Trans.). Cambridge, MA: Harvard University Press, 1988.

Ferenczi, S. (1976). The elasticity of psycho-analytic technique. In M. Bergmann & F. Hartman (Eds.), *The evolution of psychoanalytic technique* (pp. 216–227). New York: Basic Books.

Fortune, C. (1993). The case of "RN": Sandor Ferenczi's radical experiment in psychoanalysis. In L. Aron & A. Harris (Eds.), *The legacy of Sandor Ferenczi* (pp. 101–120). Hillsdale, NJ: Analytic Press.

Fossati, A., Madeddu, F., & Maffei, C. (1999). Borderline personality disorder and childhood sexual abuse: A meta-analysis study. *Journal of Personality Disorders, 13*(3), 268–280.

Freud, S. (1930). Civilization and its discontents. In J. Strachey, with A. Freud, A. Strachey, & A. Tyson (Eds. & Trans.). *The standard edition of the complete psychological works of Freud.* (Vol. 21, pp. 57–145). London: Hogarth Press.

Fromm-Reichmann, F. (1959). *Psychoanalysis and psychotherapy.* Chicago: University of Chicago Press.

Gabbard, G. (1991). Psychodynamics of sexual boundary violations. *Psychiatric Annals, 21*(1), 651–655.

Gabbard, G. (1994). On love and lust in the erotic transference. *Journal of the American Psychoanalytic Association, 42,* 385–404.

Gabbard, G. (1995). *Boundaries and boundary violations in psychoanalysis.* New York: Basic Books.

Gabbard, G. (1996a). *Love and hate in the analytic setting.* Northvale, NJ: Aronson.

Gabbard, G. (1996b). Lessons to be learned from the study of sexual boundary violations. *American Journal of Psychotherapy, 50,* 311–322.

Gabbard, G., & Lester, E. (1995). *Boundaries and boundary violations in psychoanalysis.* New York: Basic Books.

Gabbard, G., & Wilkinson, S. (1994). Management of countertransference with borderline patients. Washington, DC: American Psychiatric Press.

Ghent, E. (1990). Masochism, submission, surrender. *Contemporary Psychoanalysis, 26,* 108–136.

Gitelson, M. (1952). The emotional position of the analyst in the psychoanalytic situation. *International Journal of Psycho-Analysis, 33,* 1–10.

Glaser, J., & Kihlstrom, J. (2005). Compensatory automaticity: Unconscious volition is not an oxymoron. In R. Hassin, J. Uleman, & J. Bargh (Eds.), *The new unconscious* (pp. 171–195). New York: Oxford University Press.

Glucksberg, S., & Kayser, B. (1993). How metaphors work. In A. Ortony (Ed.), *Metaphor and thought* (pp. 401–424). New York: Cambridge University Press.

Goldberger, M., & Evans, D. (1985). On transference manifestations in male patients with female analysts. *International Journal of Psychoanalysis,* 66, 295–309.

Gonsiorek, J. C. (1989). Sexual exploitation by psychotherapists: Some observations on male victims and sexual orientation issues. In G. R. Schoener, J. H. Milgrom, J. C. Gonsiorek, E. T. Luepker, & R. M. Conroe (Eds.), *Psychotherapists' sexual involvement with clients: Intervention and prevention* (pp. 113–119). Minneapolis, MN: Walk-In Counseling Center.

Gorkin, M. (1985). Varieties of sexualized countertransference. *Psychoanalytic Review*, *72,* 421–440.

Gorkin, M. (1987). *The uses of countertransference.* Northvale, NJ: Aronson.

Gray, J. A. (1990). Brain systems that mediate both emotions and cognitions. In J. A. Gray (Ed.), Special issue of *Cognition and Emotion: Psychobiological aspects of relationships between emotion and cognition* (pp. 269–288). Hillsdale, NJ: Erlbaum.

Graybar, S., & Boutilier, L. (2002). Nontraumatic pathways to borderline personality disorder. *Psychotherapy: Theory, Research, Practice, Training, 39*, 152–162.

Green, A. (2000). The central phobic position: A new formulation of the free association method. *International Journal of Psycho-Analysis, 81,* 429–451.

Greenberg, J. R. & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory.* Cambridge, MA: Harvard University Press.

Gregory, R., & Remen, A. (2008). A manual-based psychodynamic therapy for treatment-resistant borderline personality disorder. *Psychotherapy: Theory/Research/Training/Practice, 45,* 15–27.

Griffiths, P. (1997). *What emotions really are: The problem of psychological categories.* Chicago: Chicago University Press.

Gutheil, T., & Gabbard, G. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry, 155*(3), 409–414.

Hassin, R. (2005). Nonconscious control and implicit working memory. In R. Hassin, J. Uleman, & J. Bargh (Eds.), *The new unconscious* (pp. 196–224). New York: Oxford University Press.

Hedges, L. (1983). *Listening perspectives in psychotherapy.* Northvale, NJ: Aronson.

Hess, U., & Kirouac, G. (2000). Emotion expression in groups. In M. Lewis & J. M. Haviland-Jones (Eds.), *Handbook of emotions* (pp. 368–381). New York: Guilford Press.

Heywood, C. (1995). *When boundaries betray us.* San Francisco: Harper.

Hill, C., Stahl, J., & Roffman, M. (2007). Training novice therapists: Helping skills and beyond. *Psychotherapy: Theory, Research, Practice, Training, 44*(4), 364–370.

Hirsch, I. (2008). *Coasting in the countertransference.* Hillsdale, NJ: Analytic Press.

Hirsch, I., & Roth, J. (1995). Changing conceptions of unconscious. *Contemporary Psychoanalysis, 31*(2), 263–276.

Jamison, K. R. (1999). *Night falls fast: Understanding suicide.* New York: Knopf.

Jourard, S. (1971). *Self-disclosure: An experimental analysis of the transparent self.* New York: Wiley.

Jung, C. G. (1969). Psychological aspects of the mother archetype. In M. Fordham (Ed.), *Collected works of C. G. Jung: Vol. 9, Part 1. Archetypes and the collective unconscious* (pp. 75–110). Oxford, U.K.: Pantheon Books.

Kantrowitz, J. (1995). The beneficial aspects of the patient–analyst match. *International Journal of Psycho-Analysis, 76*(2), 299–313.

Kemper, T. D. (2000). Social models in the explanation of emotions. In M. Lewis & J. M. Haviland-Jones (Eds.), *Handbook of emotions* (pp. 45–58). New York: Guilford Press.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism.* New York: Aronson.

Kernberg, O. (1994). Love in the analytic setting. *Journal of the American Psychoanalytic Association, 42,* 1137–1157.

Kernberg, O. (2003). The management of affect storms in the psychoanalytic psychotherapy of borderline patients. *Journal of the American Psychoanalytic Association, 51,* 517–544.

Knox, S., Hess, S., Petersen, D., & Hill, C. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology, 44*, 274–283.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders.* New York: International Universities Press.

Kraft-Goin, M. (2001). Borderline personality disorder: The importance of establishing a treatment framework. *Psychiatric Services, 52*(2), 167–168.

Kroll, J. (1996). Psychotherapy of borderline patients. In M. Rosenbluth & I. D. Yalom (Eds.), *Treating difficult personality disorders* (pp. 81–106). San Francisco: Jossey-Bass.

Krystal, H. (1988). *Integration and self-healing: Affect, trauma, alexithymia.* Hillsdale, NJ: The Analytic Press.

Kumin, I. (1985). Erotic horror: Desire and resistance in the analytic situation. *Journal of Psychoanalytic Psychotherapy, 11,* 3–20.

Langs, R. (1973). *The technique of psychoanalytic psychotherapy, volume 1.* New York: Aronson.

Langs, R. (1974). *The technique of psychoanalytic psychotherapy, volume 2.* New York: Aronson.

Langs, R. (1978). *The listening process.* New York: Aronson.

Lansky, M. R. (1992). *Fathers who fail: Shame and psychopathology in the family system.* Hillsdale, NJ: The Analytic Press.

LeDoux, J. (1994). Memory vs. emotional memory in the brain. In P. Ekman & R. Davidson (Eds.), *The nature of emotion: Fundamental questions* (pp. 311–312). New York: Oxford University Press.

Lester, E. (1985). The female analyst and the erotized transference. *International Journal of Psychoanalysis, 66*, 283–293.

Levenson, E. A. (1972). *The fallacy of understanding: An inquiry into the changing structure of psychoanalysis.* New York: Basic Books.

Levenson, E. A. (1993). Shoot the messenger—Interpersonal aspects of the analyst's interpretations. *Contemporary Psychoanalysis, 29,* 383–396.

Levenson, E. A. (1994). Beyond countertransference: Aspects of the analyst's desire. *Contemporary Psychoanalysis, 30*(4), 691–707.

Levenson, E. A. (1996). Aspects of self-revelation and self-disclosure. *Contemporary Psychoanalysis, 32,* 32–40.

Levin, F. (1997). Integrating some mind and brain views of transference: The phenomena. *Journal of the American Psychoanalytic Association, 45,* 1121–1152.

Lieb, K., Zanarini, M. C., Schmah, C., Linehan, M. M., & Bohus, P. (2004). Borderline personality disorder. *Lancet, 364,* 453–461.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Little, M. (1957). "R"—the analyst's total response to his patient's needs. *International Journal of Psycho-Analysis, 38,* 240–254.

Lomas, P. (1987). *The limits of interpretation: What's wrong with psychoanalysis?* New York: Penguin Books.

Luborsky, L., Auerbach, A., Chandler, M., Cohen, J., & Bachrach, H. (1971). Fac-

tors influencing the outcome of psychotherapy: A review of quantitative research. *Psychological Bulletin, 75*(3), 145–185.
Lynch, T., Thomas, R., Rosenthal, M., Kosson, D. S., Cheavens, J. S., Lejuez, C. W., et al. (2006). Heightened sensitivity to facial expressions of emotion in borderline personality disorder. *Emotion, 6*(4), 647–655.
Maltsberger, J. T. (1974). Countertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry, 30*(5), 625–633.
Mann, D. (1997). *Psychotherapy, An erotic relationship: Transference and countertransference passions.* New York: Routledge.
Margolis, M. (1994). Incest, erotic countertransference, boundary violations. *Journal of the American Psychoanalytic Association, 42,* 985–989.
Margolis, M. (1997). Analyst–patient sexual involvement: Clinical experiences and institutional responses. *Psychoanalytic Inquiry, 17,* 349–370.
Maroda, K. (1991). *The power of countertransference.* Chichester, UK: Wiley.
Maroda, K. (1998a). Why mutual analysis failed: The case of Ferenczi and RN. *Contemporary Psychoanalysis, 34,* 115–132.
Maroda, K. (1998b). Enactment: When the patient's and analyst's pasts converge. *Psychoanalytic Psychology, 15*(4), 517–535.
Maroda, K. (1999). *Seduction, surrender, and transformation: Emotional engagement in the analytic process.* Hillsdale, NJ: Analytic Press.
Maroda, K. (2002). No place to hide: Affectivity, the unconscious, and the development of relational techniques. *Contemporary Psychoanalysis, 38*(1), 101–120.
Maroda, K. (2005). Legitimate gratification of the analyst's needs. *Contemporary Psychoanalysis, 41,* 371–387.
Maroda, K. (2006). Desire, love, and power in the therapeutic relationship. *British Journal of Psychotherapy Integration, 3*(2), 6–18.
Masterson, J. F., & Klein, R. (Eds.). (1989). *Psychotherapy of the disorders of the self: The Masterson approach.* Philadelphia: Brunner/Mazel.
McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process.* New York: Guilford Press.
McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide.* New York: Guilford Press.
Meissner, W. W. (2002). The problem of self-disclosure. *Journal of the American Psychoanalytic Association, 50,* 827–867.
Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration.* Cambridge, MA: Harvard University Press.
Mitchell, S. A. (1997). *Influence and autonomy in psychoanalysis.* Mahwah, NJ: Analytic Press.
Modell, A. (1997). Reflections on metaphors and affects. *Annual of Psychoanalysis, 25,* 219–233.
Nathanson, D. (1994). Shame, compassion, and the "borderline" personality. *Psychiatric Clinics of North America, 17,* 785–810.
Nathanson, D. (Ed.). (1996). About emotion. In *Knowing feeling: Affect, script, and psychotherapy* (pp. 1–21). New York: Norton.
Ogden, T. H. (1997). Reverie and interpretation. *Psychoanalytic Quarterly, 66*(4), 567–595.

Orange, D. M. (1995). *Emotional understanding: Studies in psychoanalytic epistemology.* New York: Guilford Press.

Pally, R., in collaboration with D. Olds. (2000). *The mind–brain relationship.* London: Karnac.

Panksepp, J. (1994). Subjectivity may have evolved in the brain as a simple value-coding process that promotes the learning of new behaviors. In P. Ekman & R. Davidson (Eds.), *The nature of emotion: Fundamental questions* (pp. 313–315). New York: Oxford University Press.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.

Person, E. (1985). The erotic transference in women and in men: Differences and consequences. *Journal of the Academy of Psychoanalysis, 13,* 159–180.

Phelps, E., LaBar, K., Anderson, A., O'Connor, K., Fulbright, J., & Spencer, D. (1998). Specifiying the contributions of the human amygdale to emotional memory: A case study. *Neurocase, 4*(6), 527–540.

Pope, K. (1994). *Sexual involvement with therapists: Patient involvement, subsequent therapy, forensics.* Washington, DC: American Psychological Association.

Pope, S., Sonne, J., & Holroyd, J. (1993). *Sexual feelings in psychotherapy.* Washington, DC: American Psychological Association.

Rachman, A. W. (1993). Ferenczi and sexuality. In L. Aron & A. Harris (Eds.), *The legacy of Sandor Ferenczi* (pp. 81–100). Hillsdale, NJ: Analytic Press.

Ragen, T., & Aron, L. (1993). Abandoned workings: Ferenczi's mutual analysis. In L. Aron & A. Harris (Eds.), *The legacy of Sandor Ferenczi* (pp. 217–226). Hillsdale, NJ: Analytic Press.

Rasmussen, B., & Angus, L. (1996). Metaphor in psychodynamic psychotherapy with borderline and non-borderline clients: A qualitative analysis. *Psychotherapy: Theory, Research, Practice, Training, 33*(4), 521–530.

Regan, A. M., & Hill, C. E. (1992). Investigation of what clients and counselors do not say in brief therapy. *Journal of Counseling Psychology, 39*(2), 168–174.

Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly, 62*, 553–571.

Renik, O. (1995). The ideal of the anonymous analyst and the problem of self-disclosure. *Psychoanalytic Quarterly, 64*(3), 466–495.

Renik, O. (1999). Playing one's cards face up in analysis: An approach to the problem of self-disclosure. *Psychoanalytic Quarterly, 68*(4), 521–530.

Renik, O. (2002). Defining the goals of clinical psychoanalysis. *Psychoanalytic Quarterly, 71*(1), 117–123.

Russell, J. A. (2003). Core, affect and the psychological construction of emotion. *Psychological Review, 110,* 145–172.

Russell, J. A., Jennifer, J., Moskowitz, D. S., Zuroff, D. C., Sookman, D., & Paris, J. (2007). Stability and variability of affective experience and interpersonal behavior in borderline personality disorder. *Journal of Abnormal Psychology, 116*(3), 578–588.

Russell, P. (1998). The role of paradox in the repetition compulsion. In J. G.

Teicholz & D. Kriegman (Eds.), *Trauma, repetition, and affect regulation: The work of Paul Russell* (pp. 1–22). New York: Other Press.

Safran, J., & Muran, J. C. (2002). *Negotiating the therapeutic alliance.* New York: Guilford Press.

Schlessinger, H. J. (2003). *The texture of treatment: On the matter of psychoanalytic technique.* Hillsdale, NJ: Analytic Press.

Schore, A. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development.* Hillsdale, NJ: Erlbaum.

Schore, A. N. (2001a). The effects of a secure attachment relationship on right-brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22,* 7–66.

Schore, A. N. (2001b). The seventh Annual John Bowlby Memorial Lecture. Minds in the making: Attachment, the self-organizing brain, and developmentally-oriented psychoanalytic psychotherapy. *British Journal of Psychotherapy, 17,* 299–328.

Schore, J., & Schore, A. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal, 36*(1), 9–20.

Searles, H. (1979). *Countertransference and related subjects.* New York: International Universities Press.

Shengold, L. (1989). *Soul murder: The effects of childhood abuse and deprivation.* New Haven, CT: Yale University Press.

Spezzano, C. (1993). *Affect in psychoanalysis: A clinical synthesis.* Hillsdale, NJ: Analytic Press.

Stern, D. (1985). *The interpersonal world of the infant.* New York: Basic Books.

Stern, D. B. (1997). *Unformulated experience.* Hillsdale, NJ: Analytic Press.

Sullins, E. S. (1991). Emotional contagion revisited: Effects of social comparison and expressive style on mood convergence. *Personality and Social Psychology Bulletin, 17,* 166–174.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.

Summers, F. (1999). *Transcending the self: An object relations model of psychoanalytic therapy.* Hillsdale, NJ: Analytic Press.

Sussman, M. (2008). *A curious calling: Unconscious motivations for practicing psychotherapy* (2nd ed.). New York: Aronson.

Truax, C., & Carkhuff, R. (1965). Client and therapist transparency in the psychotherapeutic encounter. *Journal of Counseling Psychology, 12,* 3–9.

Trull, T. (2001). Structural relations between borderline personality disorder: Features and putative etiological correlates. *Journal of Abnormal Psychology, 110,* 471–481.

Tyson, R. (1985). Countertransference evolution in theory and practice. *Journal of the American Psychoanalytic Association, 34,* 251–274.

Uleman, J. S., Blader, S. L., & Todorov, A. (2005). Implicit impressions. In R. Hassin, J. Uleman, & J. Bargh (Eds.), *The new unconscious* (pp. 362–392). New York: Oxford University Press.

Vgotsky, L. S. (1978). *Mind in society.* Cambridge, MA: Harvard University Press.

Wachtel, P. (1993). *Therapeutic communication: Knowing what to say when.* New York: Guilford Press.

Wachtel, P. (2007). *Relational theory and the practice of psychotherapy.* New York: Guilford Press.

Wagner, A. W., & Linehan, M. M. (1999). Facial expression recognition ability among women with borderline personality disorder: Implications for emotion regulation. *Journal of Personality Disorders, 13,* 329–344.

Watt, D. F. (2003). Psychotherapy in an age of neuroscience: Bridges to affective neuroscience. In J. Corrigall & H. Wilkinson (Eds.), *Revolutionary connections: Psychotherapy and neuroscience* (pp. 79–115). London: Karnac.

Wegner, D. M., & Bargh, J. A. (1998). Control and automaticity in social life. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *Handbook of social psychology (*4th ed.) (Vol. 2, pp. 446–496). Boston: McGraw-Hill.

Wells, T. L. (1994). Therapist self-disclosure: Its effects on clients and the treatment relationship. *Smith College Studies in Social Work, 65,* 23–41.

Wilkinson, M. (2006). *Coming into mind: The mind–brain relationship: A Jungian perspective.* London: Routledge.

Winnicott, D. W. (1949). Hate in the counter-transference. *International Journal of Psycho-Analysis, 30,* 69–74.

Winnicott, D. W. (1956). On transference. *International Journal of Psycho-Analysis, 37,* 386–388.

Winnicott, D. W. (1963). Dependence in infant care, in child care, and in the psycho-analytic setting. *International Journal of Psycho-Analysis, 44*(3), 339–344.

Winnicott, D. W. (1974). Fear of breakdown. *International Review of Psycho-Analysis, 1,* 103–107.

Winnicott, D. W. (1986). The theory of the parent–infant relationship. In P. Buckley (Ed.), *Essential papers on object relations: Essential papers in psychoanalysis* (pp. 233–253). New York: New York University Press.

Wry, H., & Welles, J. (1994). *The narration of desire.* Hillsdale, NJ: Analytic Press.

Author Index

Altman, M., 213
Andersen, S. M., 8
Angus, L., 175
Arlow, J. A., 175
Aron, L., 58, 70, 117
Atwood, G., 218
Auerback, A., 83

B

Bacal, H. A., 83
Bachrach, H., 83
Balint, M., 62, 63, 67, 69
Barett, M. S., 12
Bargh, J. A., 8, 114
Basch, M., 136, 161
Benowitz, M. S., 218
Berano, K. C., 22
Bion, W. R., 158
Bird, B., 160
Blader, S. L., 114
Blum, H., 210, 217, 221
Bohus, P., 154
Bollas, C., 222
Borbely, A., 175
Boutilier, L., 155, 156, 167
Bridges, N., 57, 206
Bucci, W., 175
Buechler, S., 37
Bushra, A., 58

C

Capobianco, J. A., 22
Carkhuff, R., 108
Casement, P., 30, 31
Celenza, A., 55, 69, 197, 213, 216
Chaiken, S., 8
Chandler, M., 83
Clore, G. C., 118
Coen, S., 58, 206
Cohen, J., 83
Crits-Cristoph, P., 12
Curtis, R., 50, 132

D

Dalenberg, C., 199
Darwin, C., 137
Davidson, R., 139
Davis, T., 108
Dimberg, U., 137, 139
Dunn, J., 164

E

Ehrenberg, D., 113
Ekman, P., 139, 144
Elise, D., 222
Epstein, L., 111, 198
Evans, D., 213

F

Farber, B. A., 22
Ferenczi, S., 70, 98, 207
Fortune, C., 70
Freud, S., 225
Fromm-Reichmann, F., 171

G

Gabbard, G., 69, 79, 109, 132, 168, 196, 199, 204, 206, 213, 214, 217, 218, 220
Ghent, E., 191
Gibbons, M. B., 12, 171
Gitelson, M., 210
Glaser, J., 113
Glassman, N. S., 8
Glucksberg, S., 175
Goldberger, M., 213
Gonsiorek, J. C., 218
Gorkin, M., 108, 218
Govender, R., 8
Gray, J. A., 118, 140
Graybar, S., 155, 156, 167
Green, A., 163
Greenberg, J., 6
Gregory, R., 154, 175
Griffiths, P., 6, 138
Gutheil, T., 109, 132

H

Harris, A., 117
Hassin, R., 113
Hayes, J., 109
Hess, U., 6, 109, 116
Heywood, C., 208
Hill, C., 13, 15, 109, 116
Hirsch, I., 13, 33, 119, 158, 161
Holroyd, J., 213, 217

J

Jamison, K. R., 171, 172
Jennifer, J., 164
Jourard, S., 108
Jung, C., 136

K

Kantrowitz, J., 7
Kayser, B., 175
Kemper, T. D., 6, 139
Kernberg, O., 166, 199, 213, 216, 218
Kihlstrom, J., 113
Kirouac, G., 6
Klein, R., 184
Knox, S., 109, 116
Kohut, H., 219
Kraft-Goin, M., 169
Kroll, J., 167
Krystal, H., 56, 137, 139, 175, 229
Kumin, I., 209

L

Langs, R., 35, 60, 84, 85, 86, 87, 88, 99, 100, 168, 182, 197, 207
Lansky, M., 153
LeDoux, J., 140, 178
Lester, E., 213, 218
Levenson, E., 6, 87, 92, 97, 133
Levin, F., 175, 176, 177
Lieb, K., 154
Linehan, M. M., 154, 164, 165
Little, M., 122
Lomas, P., 50
Luborsky, L., 83
Lynch, T., 165

M

Maltsberger, J. T., 171
Mann, D., 206, 218
Margolis, M., 213
Maroda, K., 7, 8, 20, 28, 33, 51, 58, 70, 109, 112, 113, 117, 120, 121, 132, 133, 166, 168, 179, 196, 202, 211, 219, 239
Masterson, J. F., 184
McWilliams, N., 18, 170, 179, 183, 191
Meissner, W. W., 109
Mitchell, S. A., 6, 83, 213, 235
Modell, A., 175, 176, 177
Moskowitz, D. S., 164
Muran, J. C., 150, 196
Myers, D., 109

N

Nathanson, D., 138, 143, 161, 169

O

Ogden, T. H., 175
Orange, D. M., 140

P

Pally, R., 177
Panksepp, J., 118, 140
Paris, J., 164
Pearlman, L., 6
Person, E., 213, 216, 217, 218
Petersen, D., 109, 116
Phelps, E., 137
Pope, K., 213, 216, 217
Pratto, F., 8

R

Rachman, A.W., 107
Ragen, T., 70
Rasmussen, B., 175
Regan, A. M., 13
Remen, A., 154, 175
Renik, O., 25, 111, 113
Reznik, I., 8
Roffman, M., 15
Rosenthal, M., 165
Roth, J., 33
Russell, J. A., 8, 164, 234
Russell, P., 5

S

Saakvitne, K., 6
Safran, J., 150, 196
Schlessinger, H. J., 49, 82, 83, 88
Schmah, C., 154
Schore, A., 32, 117, 137, 138, 178
Schore, J., 138, 155
Searles, H., 6, 197, 212, 213
Shengold, L., 97
Sonne, J., 213, 217
Sookman, D., 164
Spezzano, C., 136
Stahl, J., 15
Stern, D., 117, 137, 138
Stern, D. B., 114, 137
Stolorow, R., 218
Sullins, E. S., 5
Sullivan, H. S., 33, 118, 226
Summers, F., 153
Sussman, M., 179

T

Thomas, R., 165
Todorov, A., 114
Trop, J., 218
Truax, C., 108
Trull, T., 155
Tyson, R., 218

U

Uleman, J. S., 114

V

Vgotsky, L. S., 117

W

Wachtel, P., 33, 36, 46, 82, 118, 160, 161, 186, 226, 228, 229, 230
Wagner, A. W., 165
Watt, D. F., 155
Wee-Jhong, C., 12
Wegner, D. M., 114
Wells, J., 209, 217, 218
Wells, T. L., 132
Wilkinson, M., 78, 168, 176, 177
Winnicott, D. W., 28, 119, 158, 161, 195
Wry, H., 209, 217, 218

Z

Zanarini, M. C., 154
Zuroff, D. C., 164

Subject Index

Acting out, 86, 99, 197
Advice, 131–132
Affects
  as communication, 6
  communication of, 117
Anger. *See also* Confrontation
  client anger, 193
  and conflict, 179–181
  therapist's expression of, 123, 195–197, 199–202; *see also* Hate
Awareness of self and others, 230–231

B

Beginning therapists
  anxiety in first session, 15–17
Borderline personality disorder
  affect-reading abilities, 165
  basic trust, 158–159
  boundary maintenance, 167–169
  brain dysfunction in, 154–155
  client education with, 143, 167–170
  emotional storms, 155–162, 165–167
  environmental contributions to, 154–155; *see also* Environment
  genetic contributions to, 154–155; *see also* Genetics
  grieving and affect management, 173–175; *see also* Emotion
  metaphor and the brain, 175–177; *see also* Metaphor
  pejorative use of term, 153–154
  phone calls, 170; *see also* Phone calls
  power and helplessness, 163–164; *see also* Power
  pseudo-affect in, 162–163
  shame, 161–162; *see also* Shame

C

Civilization and Its Discontents (Freud), 225
Collaborative relationship, 37–39
Coming Into Mind (Wilkinson), 176
Competing needs, 231–233
Confirmatory responses, 87–88. *See also* Responses
Confrontation
  anger, 179–181; *see also* Anger
  harmful behaviors and, 188–191
  lateness, 182–183
  money, 181–182
  regarding contradictions, 183–186
  suppressed thoughts, 192–193
Consciousness, 136–138
Countertransference
  anger and hatred, 195–197; *see also* Anger; Hate
  and suicide, 171; *see also* Suicide
Curtis, Rebecca, 132

D

Dissociation, 95. *See also* Withdrawal
Dyadic effect, 108. *See also* Self-disclosure

E

Ekman, Paul, 144
Emotion
  display rules, 139
  grieving and affect management, 173–175; *see also* Borderline personality disorder
  identifying facial expressions of, 144
  manageable levels of, 140–144
  and therapeutic action, 139–141; *see also* Therapeutic action
  and transference-countertransference interplay, 145–150
Emotional contagion, 6, 138
Emotional engagement
  lack of, 12
Empathy
  basic, 18–20
  excessive demands for, 20–22
  naturally occurring, 137
Enactment, 111–112
Environment
  contributions to personality, 138
Erotic feelings
  client's reluctance to discuss, 208–209
  client's therapeutic and nontherapeutic, 206–208, 209–212
  facilitating client's expression, 222–223
  gender differences, 216–217
  heterosexual as defense against homosexual, 217–218
  therapist's, 204–206, 208, 211–214, 216
    disclosure of, 218–219; *see also* Self-disclosure

F

Ferenczi, Sandor, 70

G

Genetics
  contributions to personality, 138
Goals, setting, 25–27
Gratification
  therapist's, 211–212
Greenberg, Jay, 6

H

Hate. *See also* Countertransference
  countertransference hate
    and anger, 195–197, 198
    and suicide, 171

I

Impasse, 121
Interventions
  evaluating, 82–84
    specific, 85–87
  responses to empathy, 17

J

Joy
  therapist's expression of, 124–125

L

Lateness
  client, 196
  therapist, 196
Levenson, Edgar, 87
Love
  and erotic feelings, 205–206, 209–214
  lovability, 233–234

M

Masochistic submission, 191, 193, 196
Match, therapeutic, 7–12, 36–37
Metaphor, 175–177. *See also* Borderline personality disorder
Mitchell, Stephen, 6

Motivations
others in client's life, 225–229
Mutual influence, 36, 49–55

N

New Unconscious, The (Hassin, Uleman, & Bargh (Eds.)), 113
Nonconfirmatory responses, 88–91, 96–98, 100. *See also* Responses
Nonverbal responses, 92–95. *See also* Responses
Note-taking, 14

P

Passive-aggressive behaviors
therapist's, 197–198, 201
Phone calls
after-hours, 70–72
with borderline clients, 170
and countertransference anger, 196
Power, 163–164, 209. *See also* Borderline personality disorder
Power of Countertransference (Maroda), 120, 218
Projective identification, 111
Psychosomatic responses, 89, 100

Q

Questions, asking, 22–25

R

Regression
basic definition, 56–60
dangers with trauma clients, 78–79; *see also* Trauma
manageable levels of, 79–80
nontherapeutic (malignant), 68–70, 161
case of, 72–77
signs and symptoms of, 60–62
therapeutic (benign), 62–68, 89–90
therapist's role in creating, 77–78
Relational patterns, 6–7, 33–37, 227
creating new, 234–238
recreation of, 31–33
Responses
confirmatory, 87–88
nonconfirmatory, 88–91, 96–98, 100
nonverbal, 92–95

S

Sadness, 124
Seduction, Surrender, and Transformation (Maroda), 32–33
therapist's expression of, 124
Seinfeld, 67
Self-disclosure
definition of, 107–108
dyadic effect, 108
erotic countertransference, 218–219
guidelines for, 120
judicious use of, 109
spontaneous, 113, 115–116
therapeutic action of, 116–120
therapist comfort with, 122
volunteering information, 133, 219
what not to disclose, 132–133
Sessions
how client begins, 84–85
Severn, Elizabeth, 70
Shame, 161–162. *See also* Borderline personality disorder
Smothers, Brian, 27
Stern, Donnel, 114
Suicide, 170–173, 185. *See also* Borderline personality disorder

T

Termination, 238–241
Therapeutic action, 116–120, 139–141. *See also* Emotion; Self-disclosure
Therapeutic alliance, 109
Third Rock from the Sun, 129
Transference-countertransference interplay, 145–150; *see also* Emotion
Trauma, 78–79, 137, 140, 199, 214–215. *See also* Regression

U

Unconscious processes, 113–114, 136–138
Unformulated experience, 115, 137

V

Vicarious traumatization, 6
Vulnerability, 56–58

W

When Boundaries Betray Us (Heywood), 208
Withdrawal, 95, 159. *See also* Dissociation